

# CATARACT SURGERY

*Cataracts are a progressive condition in which the lens of the eye becomes cloudy and grows increasingly opaque. As the cataract becomes progressively cloudy, it blurs and distorts vision to an increasing degree. Cataract surgery, by itself, is the removal of the natural lens of the eye by a surgical technique. Following cataract surgery, there are three methods of restoring useful vision: intraocular lens, glasses, contact lens.*

Patient's  
Initials

\_\_\_\_\_ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

\_\_\_\_\_ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

\_\_\_\_\_ I understand and accept that the most likely material risks and complications of cataract surgery have been discussed with me and may include but are not limited to:

- *additional treatment or surgery*
- *clouding of the outer lens*
- *damage to retina or nerve*
- *decentration of the intraocular lens*
- *detachment of the retina*
- *discomfort*
- *droopy eyelid*
- *failure to accomplish intent of surgery*
- *glaucoma*
- *hemorrhage*
- *inaccuracy of intraocular lens power*
- *increased astigmatism*
- *increased pressure in the eye*
- *infection*
- *irregular pupil*
- *long-term discomfort*
- *loss of corneal clarity*
- *loss of near focusing power*
- *loss of vision and/or eye*
- *no change to vision*
- *perforation of the eye*
- *period of imbalance between the two eyes*
- *retained pieces of cataract in the eye*
- *swelling*
- *worse vision*
- *wound leak*

\_\_\_\_\_ I understand and accept the additional possible risks and complications of the insertion of the intraocular lens, which include but are not limited to:

- *bleeding in the eye*
- *continued need for glasses*
- *dislocation of the lens*
- *inability to dilate the pupil*
- *increased night glare and/or halo, double or ghost images*
- *iris atrophy*
- *loss of corneal clarity*
- *need for lens exchange*
- *uveitis*
- *wrong power*

\_\_\_\_\_ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.

\_\_\_\_\_ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

\_\_\_\_\_ I have informed the doctor of all my known allergies.

\_\_\_\_\_ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

\_\_\_\_\_ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.

\_\_\_\_\_ I am aware and accept that no guarantees about the results of the procedure have been made.

\_\_\_\_\_ I have been advised of the probable consequences of declining recommended or alternative therapies.

\_\_\_\_\_ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

\_\_\_\_\_ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

\_\_\_\_\_ The doctor has answered all of my questions regarding this procedure.

*Continued*

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct \_\_\_\_\_, M.D., with associates or assistants of his or her choice, to perform cataract surgery and/or implantation of intraocular lens on \_\_\_\_\_ at \_\_\_\_\_, on the  right eye  left eye  
(patient name)  
(name of facility)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

\_\_\_\_\_  
Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient or Legal Representative Name

\_\_\_\_\_  
Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the proposed treatment and the risks and consequences of not proceeding, have offered to answer any questions and have fully answered all such questions. I believe that the patient/legal representative (circle one) fully understands what I have explained.

\_\_\_\_\_  
Physician Signature/Date/Time

\_\_\_\_\_ copy given to patient  
initial

\_\_\_\_\_ original placed in chart  
initial

