CLEAR LENS EXTRACTION (Refractive Lensectomy)
FOR THE CORRECTION OF
HYPEROPIA (Farsightedness) or HIGH MYOPIA (Nearsightedness)

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 risks and complications of Refractive Lensectomy 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 this use of the intraocular lens is considered “off-label.”

_____ 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 avoid taking 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.

3/03
Revised 9/05, 12/05, 1/06, 6/07

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).
The doctor has answered all of my questions regarding this procedure.

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 clear lens extraction for hyperopia/myopia (circle one), which involves the removal of the clear lens of the eye and replacement with an artificial implant called an intraocular lens, on __________________________ at __________________________, on the

☐ right eye  ☐ left eye

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 procedure to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

________________________________
Physician Signature/Date/Time

_______ copy given to patient                                              _______ original placed in chart
initial                                                                                 initial

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