

**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 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.

\_\_\_\_\_ 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  
initial

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