

GLAUCOMA SURGERY LASER TRABECULOPLASTY

Glaucoma is a condition in which fluid in the eye is blocked, causing increased pressure that can impair the functioning of the retina and optic nerve. Laser surgery helps fluid drain out of the eye. A high-energy beam of light is aimed at the lens and reflected onto the meshwork inside the eye, which makes evenly spaced drainage holes in the meshwork. This helps to open the holes and lets fluid drain better through them.

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 glaucoma surgery have been discussed with me and may include but are not limited to:

- *abnormal collection of fluid in the eye*
- *additional treatment or surgery*
- *anesthesia complications*
- *bleeding in or behind the eye*
- *chronic inflammation*
- *closure of drain*
- *development or worsening of cataract*
- *failure to accomplish intent of surgery*
- *increase or decrease of pressure in the eye*
- *infection*
- *loss of vision and/or eye*
- *no change to vision*
- *persistent irritation or discomfort in the eye*
- *possible drooping of eyelid*
- *retinal or choroidal detachment*
- *worse vision*

_____ 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.

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

Continued

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform glaucoma surgery on _____ at _____, on the _____
(patient name) *(name of facility)*

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 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

initial copy given to patient

initial original placed in chart