

LASER THERMAL KERATOPLASTY (LTK)

Laser thermal keratoplasty (LTK) is one of a number of alternatives for correcting hyperopia (farsightedness). In LTK, the laser gently heats eye tissue outside the center of the cornea, causing it to steepen and reduce farsightedness.

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 laser thermal keratoplasty have been discussed with me and may include but are not limited to:

- anesthesia complications
- balance problem between the eyes after LTK has been performed on one eye, but not other
- corneal haze
- damage to cornea caused by scarring, ulceration, or an eye infection
- drooping of eyelids
- failure to accomplish intent of surgery
- increased astigmatism, which may cause blurred vision
- increased sensitivity to light
- infection
- long-term effects are unknown
- loss of vision or loss of best-corrected vision
- may not receive full correction from LTK procedure necessitating future procedures or use of glasses or contact lenses
- no change to vision
- only temporary correction
- overcorrection, causing either permanent or treatable nearsightedness
- pain, scratchiness, a foreign body sensation, or slight dryness of the eye
- visual acuity gained from LTK could regress
- 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.

I authorize and direct _____, M.D., with associates or assistants of his or her choice,

to perform laser thermal keratoplasty on _____

at _____, on the _____ (patient name)

(name of facility)

right eye

left eye

Continued

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

