

PHOTOREFRACTIVE KERATECTOMY (PRK)

Photorefractive keratectomy (PRK) is an irreversible procedure to improve nearsightedness (myopia), farsightedness (hyperopia), or astigmatism by using an excimer laser.

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

- *a feeling that something is in the eye*
- *astigmatism*
- *blurred vision*
- *corneal scarring*
- *corneal swelling*
- *decrease in best-corrected visual acuity*
- *difficulty with night vision*
- *double vision*
- *drooping of the eyelid*
- *failure to accomplish intent of surgery*
- *formation of cataracts*
- *haze/glare/halo-affected vision*
- *increase in inner eye pressure*
- *infection*
- *loss of vision and/or eye*
- *no change to vision*
- *pain*
- *partial or complete loss of vision*
- *sensitivity to light*
- *shadow images*
- *tearing*
- *under or overcorrection*

_____ I understand that after the PRK procedure, I may still require corrective lenses.

_____ 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 photorefractive keratectomy 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

_____ copy given to patient
initial

_____ original placed in chart
initial