

RADIAL KERATOTOMY (RK)

Radial keratotomy (RK) is a procedure that is used to correct myopia (nearsightedness) by surgically changing the curvature of the cornea over the pupil using tiny incisions that flatten the cornea to change the way it focuses. Keratotomy literally means "cutting the cornea."

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

- *cataract*
- *chance of overcorrection (hyperopic shift, over time)*
- *corneal and other types of infection; ulcers and enlargement of blood vessels*
- *eye fragility to trauma from impact*
- *failure to accomplish intent of surgery*
- *halos; sensitivity to glare, especially at night*
- *infection*
- *irregular astigmatism*
- *long-term effects on cornea are unknown but may include corneal thinning or clouding, requiring corneal transplant*
- *loss of vision and/or eye*
- *no change to vision*
- *pain*
- *post-operative vision may be worse than preoperative vision and may not be correctable with standard glasses or contact lenses*
- *scar on cornea may be visible to me and others*
- *vision may fluctuate*

_____ 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 radial keratotomy on _____ at _____, my
(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

