DISCLOSURE AND CONSENT FOR SURGICAL, MEDICAL, AND DIAGNOSTIC PROCEDURES

To The Patient:
You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is simply an effort to better inform you so you may give or withhold your consent to the procedure.

I (we) voluntarily request **Dr. Stephen Slade** as my physician, and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition which has been explained to me as:

Cataract_____Eye

(Please fill in which eye is being operated on.)

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent to and authorize these procedures:

(PE-IOL) Phaco Emulsification with Intra Ocular Lens_____Eye

(Please fill in which eye is being operated on.)

I (we) understand that my physician may discover other or different conditions, which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I (we) ☐ (Do) ☐(Do Not) consent to the use of blood and/or blood products as deemed necessary.
I (we) understand that no warranty or guarantee has been made to me as to results or cure.
Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) realize that the following risks and hazards may occur in connection with his particular procedure:

(PE-IOL) Phaco Emulsification with Intra Ocular Lens_____ Eye

(Please fill in which eye is being operated on.)

I (we) understand that anesthesia involves additional risks and hazards, but I (we) request that use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth, or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about the condition, alternative anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) ☐ (Do) ☐(Do Not) authorize my doctor and/or such assistants as he/she may select to photograph or video tape me.
I (we) understand that the photographs/video will be used only for medical and educational purposes and will not be released for publication in any other context without my expressed written permission.

SEE THE BEST
SLADE & BAKER
VISION CENTER

Patient Identification

Anesthesia

General: Risks are enumerated in the Disclosure and Consent for Surgical Medical Procedures.

_____

(INITIALS)

Eye Treatments And Procedures

☐ A. Eye muscle surgery
- 1. Additional treatment and/or surgery
- 2. Double vision
- 3. Partial or total loss of vision

☒ B. Surgery for cataract with or without implantation of intraocular lens.
- 1. Complications requiring additional treatment and/or surgery
- 2. Need for glasses or contact lenses
- 3. Complications requiring the removal of implanted lens
- 4. Partial or total loss of vision

C. Retinal or vitreous surgery

☐
- 1. Complications requiring additional treatment and/or surgery
- 2. Recurrence or spread of disease
- 3. Partial or total loss of vision

D. Reconstructive and/or plastic surgical procedures of the eye and eye region; such as

☐ blepharoplasty, tumor, fracture, lachrymal surgery, foreign body, abscess or trauma
- 1. Worsening or unsatisfactory appearance
- 2. Creation of additional problems such as:
  - a. Poor healing or skin loss
  - b. Nerve damage
  - c. Painful or unattractive scarring
  - d. Impairment of regional organs, such as eye or lip function
- 3. Recurrence of original condition

E. Photocoagulation and/or cryotherapy

☐
- 1. Complications requiring additional treatment and/or surgery
- 2. Pain
- 3. Partial or total loss of vision

F. Corneal surgery such as: corneal transplant, partial corneal transplant, refractive surgery, and pterygium

☐
- 1. Complications requiring additional treatment and/or surgery
- 2. Possible pain
- 3. Need for glasses or contact lenses
- 4. Partial or total loss of vision

G. Glaucoma surgery by any method

☐
- 1. Complications requiring additional treatment and/or surgery
- 2. Worsening of the glaucoma
- 3. Pain
- 4. Partial or total loss of vision

H. Removal of the eye or its contents (enucleation or evisceration).

☐
- 1. Complications requiring additional treatment and/or surgery
- 2. Worsening of or unsatisfactory appearance
- 3. Recurrence or spread of disease

I. Surgery for pentrating ocular injury, including intraocular foreign body.

☐
- 1. Complications requiring additional treatment and/or surgery including removal of eye
- 2. Chronic pain
- 3. Partial or total loss of vision

Patient Identification

_____

(INITIALS)

The following treatments and procedures require **no disclosure** by the physician or health care provider to the patient or person authorized to consent for the patient.

☒ A. Anesthesia
1. Local
2. Other forms of regional anesthesia

☒ B. Eye
1. Administration of topical, parenteral (such as IV), or oral drugs or pharmaceuticals, including but not limited to fluorescein angiography, orbital injection or periocular injections
2. Removal of extra ocular foreign bodies
3. Chalazion excision

❑ C. Musculoskeletal System
1. Arthrotomy
2. Closed reduction without fixation
3. Excision of lesion, muscle, tendon, fascia, bone
4. Excision of semilunar cartilage of knee joint
5. Needle biopsy or aspiration, bone marrow
6. Partial excision of bone
7. Removal of internal fixation device
8. Traction or fixation without manipulation for reduction

I (we) ❑ **(Do)** ❑ **(Do not)** consent to the disposal of any tissues or parts that may be removed in accordance with customary practice.

For the purpose of advancing medical education, I (we) ❑ **(Do)** ❑ **(Do not)** consent to the admittance of students and persons required for technical support to the room in which the procedure is performed.

I (we) understand that I am scheduled to go home after my surgery and I must have a responsible adult drive me home and stay with me as advised by my physician.

I (we) understand the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other facility should my physician(s) deem it advisable or necessary.

I (we) understand the Surgical Center is not responsible or liable for the loss of or damage to any article of value that I have brought to this facility.

I (we) understand that Texas law provides and I (we) agree, that if any healthcare worker is exposed to my blood or other bodily fluid, to allow River Oaks Surgical Center to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, hepatitis and human immunodeficiency virus (which is the causative agent of AIDS). I (we) understand that such testing is necessary to protect those who will be caring for me while I am a patient of the Surgical Center. I (we) understand that the results of such tests do not become a part of my medical record.

The nature, purpose, and possible complications of the procedure and medical services described above, risks and benefits reasonably expected, and the alternative methods of treatment have been explained to me (us) by the physician, and I (we) understand the explanation I (we) have received.

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM. The surgeon has disclosed the comparative risks, benefits, and alternatives associated with performing this procedure in the ambulatory surgical facility instead of in a hospital.

I have explained the procedure, risks, hazards, and benefits to the patient and have obtained informed consent.

PHYSICIAN SIGNATURE: _____ Date: _____

Signature _____ _____

Patient/Legally Designated Representative Date Witness Time

_____

Interpreter

If the patient is a minor or unable to sign, complete the following:

❑ Patient is a minor

❑ Patient is unable to sign because _____

_____

Relationship to Patient if Patient Does Not Sign

Patient Identification