MOUNT OGDEN
BOUNTIFUL HILLS
EYE CENTERS

CONSENT FOR VITREORETINAL SURGICAL PROCEDURES

You have been given information about your condition and the recommended surgical procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. **Condition:** Dr. Alldredge has explained to me that I have the following condition(s):

   _____

2. **Proposed Procedure(s):** I understand that the procedure(s) proposed for treating my condition is/are:

   _____

   _____

3. **Risks/Benefits of Proposed Procedure(s):**

   A. Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.

   B. I also realize that there are particular risks associated with the procedure(s) proposed for me and that these risks include, but are not limited to:

Complications which could occur weeks, months, or even years later

1. Failure to accomplish intent of surgery
2. Retinal detachment or macular puckering that may require additional surgery or may be inoperable
3. Vitreous or Choroidal hemorrhage (bleeding)
4. Infection
5. Elevated eye pressure (glaucoma)
6. Poorly healing or non-healing corneal defects
7. Corneal clouding and scarring
8. Cataract, which might require eventual or immediate removal of lens
9. Damage to an intraocular lens implant, if present
10. Double vision
11. Eyelid droop

Patient Initials_____

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12. Loss of circulation to vital tissues in the eye, resulting in decrease or loss of vision.
13. Permanent blindness, or diminished visual acuity or field
14. Loss of eye or vision
15. Temporary or permanent inflammation and or irritation
16. Alteration in the appearance of the eye

Complications of local anesthesia injections around the eye:

1. Perforation of eyeball
2. Destruction of optic nerve
3. Interference with circulation of retina
4. Possible drooping of eyelid
5. Respiratory depression
6. Hypotension

4. **Complications; Unforeseen Conditions; Results:** I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment

5. **Acknowledgments:** The available alternatives, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment, have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

6. **Consent to Procedure(s) and Treatment:** Having read this form and talked with the physicians, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted by hospital personnel and other trained persons as well as the presence of observers.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date