



SKYVISION CENTERS

INFORMED CONSENT FOR LASER VISION CORRECTION

This is to serve as an educational form for you, the patient, on the risks you will undertake if you proceed with laser vision correction. LASIK is an elective procedure. You have options other than this surgery to correct your nearsightedness, farsightedness, and/or astigmatism. Some of this form will require you write out statements, further emphasizing points you need to consider. Some portions will only require your initials. Your reading of the entire document and your hand-written statements will require the signature and initials of a witness. Your witness may be a friend or family member as it is important they, too, understand the risks of the procedure. This form will be collected from you prior to your surgery. A copy of this form will be made available to you at your request.

GENERAL DESCRIPTION:

Photo-Refractive Keratectomy (PRK) or Laser In-Situ Keratomileusis (LASIK) resurfaces or flattens the top layer of the cornea. The Excimer Laser is a medical device that uses ultraviolet light energy to reshape the surface of the cornea. The brand name of the Excimer used for your procedure is the FDA approved Bausch and Lomb (more information on this device is available). The cool beam of the Excimer laser has the ability to vaporize very small amounts of tissue, one microscopic layer at a time. This allows the laser to reshape the cornea so that visible light entering the eye is focused properly, resulting in a possible reduction or correction of my nearsightedness or farsightedness, with or without astigmatism. PRK and LASIK use the laser in a similar fashion. The difference between the two surgeries is the treatment of the outermost layers of cornea.

Initials: _____

Witness: _____

I understand that I will be lying on my back during the procedure. Surgery will be performed under, either, a topical or a local anesthetic and while there will be little or no pain during the actual procedure; I can expect varying degrees of pressure sensation and/or discomfort.

For the LASIK procedure, an instrument called a microkeratome (similar in design to a small, precise carpenter's plane) is used to create a thin (about the thickness of cellophane) flap of corneal tissue. Dependent upon the surgeon's decision, the flap can vary from 6mm to greater than 9mm in diameter. The flap, or door, maintains contact with my eye as the surgeon has left a "hinge." The flap is then folded back in such a way that the Excimer Laser can be used to remove microscopic layers of tissue from the underlying cornea. Once the laser treatment is completed, the flap is then returned to its original position on the front of the surface of my eye. The result is a change to the corneal curvature, thereby, reducing or correcting nearsightedness or farsightedness.

I understand I may experience some mild pain postoperatively and severe pain in very unusual circumstances.

Initials: _____

Witness: _____

POSSIBLE COMPLICATIONS:

I recognize that any surgical procedure presents potential risks. I understand that laser surgery may make my vision worse, with or without corrective lenses.

I understand that some risks may result in vision that is not a perfect 20/20, with or without corrective lenses.

I understand that for optimum vision, I may need distance glasses and that, if I am near or over 35 years old, it is likely I will need reading glasses after this procedure.

Initials: _____

Witness: _____

The risks associated with Excimer laser surgery with or without automated lamellar keratoplasty (creation of the flap) may include, but are not limited to, corneal perforations (holes); incomplete or irregular flap creations resulting in the rescheduling of the laser portion for a minimum of three months; corneal scarring; recurrent corneal erosions; striae (wrinkling of the flap); corneal infection or ulceration; and dry eyes (temporary to permanent). In some instances, additional steps may be taken to aid a dry eye condition, such as saturation with artificial tears, punctual plugs (for my tear ducts), or usage of an oral supplement. Further complications may include, but are not limited to, cataract formation; intraocular infection; double vision; chronic pain or discomfort; over-correction of vision; and under-correction of vision.

By having treatment on both eyes at the same time, or **bilateral surgery**, I recognize that I could have one or more of these problems in both eyes at the same time. If there is over-correction or under-correction in one eye, chances are it may happen in both eyes. If a re-treatment is required in one eye, it is possible that your fellow eye may also require a re-treatment. If you are over the age of 40, by having one eye done at a time, you will have an opportunity to experience the change in your close vision that results from the correction of your nearsightedness or farsightedness. This could influence your decision on whether or not to fully correct your other eye to maintain some degree of close vision without the need for glasses (**monovision**).

By having one eye done at a time, however, there may be a period of imbalance in vision between your two eyes, producing a form of double vision. If you are able to wear a contact lens this may help this imbalance. The balance between your two eyes will usually be restored more rapidly if they are operated on the same day. It may be more convenient and create less down time from work to have both eyes done on the same day. I understand that it may be necessary for me to wear a contact lens or glasses to effect useful vision, and there is a possibility that this may not restore useful vision. I understand I may no longer be able to wear contact lenses, even if necessary, because of the change in the shape of my cornea. It is possible, that in my body's healing response, my vision regresses over time, thus returning to a state of nearsightedness, farsightedness, and/or astigmatism. Further, it is possible that the desired results of the surgery may not be obtained and that, at a later date it may become necessary to have further correction. This further correction may be obtained by additional surgery, or enhancement, which may vary from the preliminary procedure by the treatment of the flap. Determined by the surgeon, after the allowed recovery time, if the enhancement is deemed appropriate by the surgeon, the flap may be lifted rather than re-cut with the microkeratome. I understand after a lifted enhancement it is common to experience more irritation during the healing process. I understand that if the time after the initial procedure is extensive (determined by the surgeon) my flap may be re-cut with the microkeratome.

After the surgery, I may experience starburst-like images around lights, glare or halos around lights, and that my night vision may be compromised. I understand that my depth perception may be slightly altered, and image size may appear slightly different, all of which may affect my ability to drive and judge distances.

Please circle your response: **BILATERAL SURGERY**

"I wish to have both eyes done at the same time."

YES

NO

I understand if I choose to have one eye done at a time, I will need to adjust my eyeglasses and/or contact lenses and may experience difficulty with depth perception and activities dependent upon depth perception, such as driving.

Please handwrite and initial the following statements:

"I understand I may not achieve the quality of vision I had hoped for. There are no guarantees."

"I understand I may need corrective lenses after the laser procedure."

Initials: _____

Witness: _____

MONOVISION:

I understand the option of monovision. I understand that my dominant eye will be corrected to see distance and my non-dominant eye will be left under-corrected to see close. I understand that by choosing monovision, I may sacrifice some distance, as well as, near clarity for a more "functional" near and far vision. I understand that by opting for monovision, I may experience more glare and halos. I understand that, while this may reduce my need for reading glasses in most situations, it may not eliminate that need and that I may need glasses to drive, especially at night.

Please circle your request:

MONOVISION: YES NO

I understand that while this surgery may improve my vision, it will not alter the anatomical state of my eye. My eye will always be classified as a myopic or hyperopic eye even though mechanical changes have been made affecting my cornea. As a myopic eye it may be subject to such difficulties as retinal detachment and other incidences not related in any way to this type of surgery. I understand LASIK does not alter the aging process of my eyes, and that it does not prevent age related disorders from occurring. I understand that should I develop an age related disorder, it is likely to negatively affect my vision.

I understand I have unique characteristics about my eye which may affect my surgical outcome, such as pupil size, corneal thickness, and topographical (or surface) changes. I understand I am unique in my healing response and that I cannot anticipate my eyes healing at the same rate or in the same manner as others'.

Since it is impossible to state every complication that may occur as a result of any surgery, I understand that this list of complications may be incomplete and that there may be risks associated with this surgery that are currently unknown. I understand other options are available to correct my vision and that I may have this information upon request.

Please hand-write the following statement:

"I feel all my questions have been answered."

Initials: _____

Witness: _____

PRK OPTION:

I understand under certain conditions, my surgeon may feel it is in my best interest to switch from LASIK to PRK in the surgery suite. I understand the differences between the procedures, have received information on the risks and benefits of both surgeries and acknowledge the potential need.

Please circle your response:

YES, I will allow the switch to PRK if necessary.

NO, I will NOT allow the switch to PRK.

I agree to allow my procedure to be observed. **YES** **NO**

I understand the requirements of my follow-up care and am willing, if circumstances require, to see a doctor other than my operating surgeon for my follow-up visits. I understand and permit information derived from these visits to be shared among my eye care professionals.

I understand the potential benefit, which may be derived from my surgery, is a reduction or correction of my nearsightedness, farsightedness, and/or astigmatism. I may see well enough after surgery that I will not require any corrective lenses.

Acknowledging all of the above, I hereby willingly give my consent to have LASIK surgery or laser PRK performed on my eye(s).

PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____

WITNESS NAME: _____ **DATE:** _____

WITNESS SIGNATURE: _____

My staff and I have discussed this procedure with the patient (and his or her legally authorized representative) using language which is understandable and appropriate. I believe that I have fully informed this patient of the nature of this procedure and its possible benefits and risks, and I believe the participant understood this explanation.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____