

INFORMED CONSENT FOR LASER CAPSULOTOMY

INTRODUCTION

This information is offered to patients who have been diagnosed with opaque capsules that are candidates for removal by laser. The purpose of this paper is that you can make an informed decision about whether or not subjected to this procedure.

Take the time that you deem necessary to decide whether or not signing this informed consent. You have the right to ask questions about this or any other proceeding before accessing it and sign any document.

As part of cataract surgery, the capsule membrane or where the cataract was preserved for placement of the intraocular lens.

This membrane or sac will be dull and blurred vision and/or halos or starbursts around lights. These visual symptoms may worsen over time deteriorating the quality of your vision.

The laser capsulotomy is a surgery that is performed in the doctor's office using anesthetic drops. The laser opens an opening in the capsule thus restoring his vision before it dulled, as long as your retina is in perfect condition. This procedure may require more than one visit to complete.

ALTERNATIVE TREATMENT

You may decide not to have a laser capsulotomy surgery at this time. Alternative treatments if you decide not operated are:

1. **Glasses or contact lenses:** You may choose to use glasses or contact lenses but they cannot improve their visual condition and whether improvement can be for a limited time as opaque capsules tend to progress over time thus worsening vision.

2. **Note:** You can opt for no treatment and observed periodically until you understand that you need laser surgery.

CONSENT FOR LASER CAPSULOTOMY

By signing this permission for laser capsulotomy state that I understand the following:

- 1) That the laser capsulotomy is a surgical technique.
- 2) That although rare, possible complications of laser capsulotomy could include:
 - a) Dizziness during the procedure.
 - b) Change in visual acuity, which in turn results in the need for glasses or a change in your current prescription glasses, if you already used them.
 - c) New Float (transient or permanent) after the procedure.
 - d) Transient increase in pressure inside the eye drops requiring treatment.
 - e) Bleeding inside the eye transient requiring another visit to complete the treatment.
 - f) Retinal detachment requiring the intervention of a sub - specialist for repair.
 - g) Swelling of the retina (macula edema) requiring medical treatment drops or injections into the eye
 - h) Infection inside the eye (endophthalmitis) requiring the intervention of a sub - specialist to treat it.
 - i) Intraocular lens dislocation requiring reoperation to reposition or exchange instead.
 - j) Damage to intraocular lens brand created by the laser usually has no effect on your vision.
- 3) As in any surgical procedure, the results of the surgery cannot be guaranteed and may need additional treatment.

- 4) I understand that the laser capsulotomy is not an exact science and I accept that you may need to wear eyeglasses or contact lenses after surgery to get a better look.
- 5) That there is the possibility of the need for subsequent surgeries.
- 6) To alternate treatments laser capsulotomy, the basic procedures of the method, advantages and disadvantages, risks and benefits and possible complications of treatment have been explained to me by the doctor.
- 7) That although it is impossible for the doctor every possible complication that may occur I report the doctor has answered all my questions to my satisfaction.
- 8) I authorize the Institute to take pictures/videos to the end of my doctor and for purposes of medical education or scientific research, provided that is not identified by name in the same record, I also authorize the presence of observers in the operation, provided where with the consent of my doctor.

By signing this informed consent for laser capsulotomy consent I am stating that:

- 1) I'm **over 21** and **I was not forced or coerced** to undergo this surgery.
- 2) **I have read** (or had read to me) this informed consent and **fully understand** the potential risks, complications and benefits that may result from this surgery.

I have been given the opportunity to submit any questions you have and you have answered all the questions I completely and satisfactorily.

I agree to freely and voluntarily submit to the kind of operation I indicated by my signature:

- 1) I wish to have a laser capsulotomy in my eye

_____:

Patient Signature (or person authorized to sign for patient)

Patient Name PRINT

Age

Date

Signature of Witness Date

Signature of Doctor Date