



**PATIENT CONSENT FORM(S)**

**FOR**

**LASIK**

(Laser In Situ Keratomileusis)

and

**PRK**

(Photorefractive Keratectomy)

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1. I understand that I am a candidate for **LASIK (LASIK IN SITU KERATOMILEUSIS) SURGERY**, a form of laser surgery where a surgeon will anesthetize my eye with a topical anesthetic, create a flap from my cornea using a specialized instrument called a microkeratome, and use an excimer laser to reshape the cornea.

Patient initial for **LASIK**: \_\_\_\_\_

OR

I understand that I am a candidate for **PRK (PHOTOREFRACTIVE KERATECTOMY) SURGERY**, a form of outpatient surgery in which a surgeon uses a device called an excimer laser to reshape the cornea.

Patient initial for **PRK**: \_\_\_\_\_

**LASIK** or **PRK**, the identified surgery, is referred to as the "Procedure" in the following.

2. I understand the Procedure will be performed by Desikan Kadambi, M.D. ("my surgeon") on this \_\_\_\_\_ day of \_\_\_\_\_ 2001
  - (i) **both eyes** (INITIAL) \_\_\_\_\_; or
  - (ii) on \_\_\_\_\_ (DATE) **my right eye** (INITIAL) \_\_\_\_\_  
on \_\_\_\_\_ (DATE) **my left eye** (INITIAL) \_\_\_\_\_
3. I have reviewed the Surgical Information Package for **LASIK** surgery and for **PRK** and I have discussed the Procedure that I am to receive with an eye care professional at the clinic and with my surgeon.
4. The nature of the Procedure, the possible complications and risks, as well as the possible benefits or the Procedure, the alternatives to the Procedure and the risks and benefits of those alternatives have been explained to me in language and using terminology that I understand. My surgeon has answered all of my outstanding questions about the procedure.
5. I understand that this Procedure is an elective surgical procedure, and that there is no emergency of medical condition that requires that I have the Procedure.
6. Neither my surgeon nor the clinic staff has made any promises or warranties or guarantees as to the success or effectiveness of the Procedure. I have been advised that after the Procedure my vision may not be as clear and sharp as it was with glasses or contact lenses before the Procedure.
7. I understand that the Procedure may not eliminate the need for corrective lenses for all activities. I may need glasses or contact lenses for reading, driving, or certain other activities even if I did not wear them before the Procedure. I also understand that the Procedure can

unmask the need for reading glasses and that I may have to use them after the Procedure even if I did not wear them before.

8. I understand that after the Procedure I may experience side effects such as pain, discomfort and scratchiness, halos, blurry vision or fluctuations in vision, which may be temporary or could be permanent. I have been advised that I may find some of these side effects difficult to tolerate.
9. I understand that there are numerous risks and complications, both known and unknown, connected with the Procedure. These can include but not be limited to infection, hemorrhage, delayed healing, under or over correction, and other risks and complications that could affect my vision and my general health on temporary or permanent basis, and could require additional surgery, including but not limited to re-treatment or a cornea transplant. Those risks also include, but are not limited to, partial or total blindness, loss of a cornea, retinal damage or loss of an eye.
10. I understand that the Procedure is a relatively new procedure and that little is known about its long-term safety and effectiveness.
11. I understand that the Procedure does not correct certain vision problems including but not limited to amblyopia, strabismus, presbyopia and cataracts.
12. I understand that the field of refractive surgery is continuing to evolve and that if I were to postpone my surgery there is the possibility that the LASIK and/or PRK procedure might be improved or some other procedure might become available.
13. I understand that my surgeon is a medical doctor and a board certified ophthalmologist and ophthalmic surgeon who is experienced with LASIK and/or PRK and/or laser refractive surgeries and has been credentialed to meet standards required for certification by the College of Physicians and Surgeons of Manitoba and the Royal College of Surgeons of Canada, and a Board Certified ophthalmologist in the United States.
14. I understand that I will need certain post-operative care. The day after my surgery I will return to the clinic for a post-operative visit that will include an examination by my surgeon. My surgeon at the clinic will provide additional post-operative care, with referral back to my optometrist or surgeon if indicated. All post-operative care at the clinic (except for the cost of corrective lenses, punctal plugs or the cost of certain medications) is included in my fee. I understand that if I so desire, I may make other arrangements for post-operative care at my own expense.

I confirm that I have made arrangements to have my post-operative care provided by \_\_\_\_\_ who is an optometrist / ophthalmologist (circle one) in \_\_\_\_\_.

15. I have had the opportunity to ask questions about the Procedure and all of my questions have been answered satisfactorily.
16. I give my surgeon permission to use data about my treatment for research purposes. I understand that my name and personal identifying information will remain confidential, unless I give written permission to disclose this information.  
*(Patient may delete this clause when choosing not to participate in research activities)*
17. I understand that the applicable governing law for this procedure is the law of the Province of Manitoba.
18. I understand that I hold only my surgeon, and **NOT** Eyetech Lasik Clinic Inc. responsible to me for any and all acts of commission and omission.
19. I give my surgeon permission to videotape or photograph the Procedure. *(Patient may decline to be videotaped and may delete this clause.)*
20. I understand that if I require an enhancement surgery there will be a fee for the assessment and for the re-treatment.
21. I am not under the influence of any sedative. I am of clear mind and understand the nature of the Procedure and the possible risks related to the Procedure.

**I understand that by signing below, I am indicating that I have read and understood the information in this Patient Consent Form; that I have been verbally advised about the Procedure, that I have had an opportunity to ask questions, that I have received all of the information I desire concerning the Procedure and that I authorize and consent to the performance of the Procedure and any different or further procedures which in the opinion of my surgeon are necessary due to an emergency.**

**Patient Name (print):** \_\_\_\_\_  
**Patient Signature:** \_\_\_\_\_  
**Surgeon Name:** Desikan Kadambi M.D.  
**Surgeon Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Certification by Surgeon**

**I, Desikan Kadambi M.D. hereby certify that:**

1. I have discussed and explained **LASIK (Laser in Situ Keratomileusis) or PRK (Photorefractive Keratectomy)** (*circle one*), referred to as the Procedure, the risks and benefits of the Procedure, the alternatives to the Procedure and the risks and benefits of the those alternatives with \_\_\_\_\_ (the patient).
  
2. The patient is a suitable candidate for **LASIK or PRK** (*circle one*) given the ophthalmic findings and the patient's physical, social, emotional and/or occupational needs.
  
3. I have discussed any special circumstances with the patient and the addition potential risks posed by those special circumstances, including the following:  
(TO BE COMPLETED BY SURGEON)  
  
\_\_\_\_\_  
  
\_\_\_\_\_
  
4. I have discussed the arrangements for post-operative care with the patient who has agreed to the plan for post-operative care.
  
5. I have answered all of the patient's questions about the Procedure.
  
6. I have ascertained that the patient fully understands the answers to questions that he/she posed to me.
  
7. I have ascertained that the patient fully understands the risks, benefits and possible alternatives to the Procedure.

Name of Surgeon: Desikan Kadambi M.D.

Surgeon Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Consent Form Addendum/Confirmation

Please read and initial the following sentences to confirm that you agree and clearly understand them.

1. I have decided that the benefits of surgery outweigh the potential for complications.
2. I understand that my vision under low lighting conditions may be impaired, particularly with respect to night vision disturbances such as glare and halo and that eyeglasses or contact lenses may not be able to correct these.
3. I understand that in the event of a serious complications, my vision could be blurred, doubled or distorted and that neither eyeglasses nor contact lenses would be able to correct this.
4. I understand that I will still need eyeglasses for near vision at or about the age of 40.

This form highlights only some of the important concepts I need to understand before undergoing surgery. I understand that other information in the Surgical Information Packet and Consent Form for LASIK (Lasear in Situ Kertomieusis) and PRK (Photorefractive Keratectomy) may be equally or more important for my situation.

**My surgeon discussed all of the above prior to my surgery and I have signed this in his presence before going ahead with the surgery.**

Patient's signature: \_\_\_\_\_

Surgeon's signature: \_\_\_\_\_

Date: \_\_\_\_\_