Valley Surgery Center
A COVENANT SURGICAL PARTNER

Physician: _____

Planned Procedure(s) and Complications

☐ **YAG Laser Posterior Capsulotomy of the right eye**

☐ **YAG Laser Posterior Capsulotomy of the left eye**

Possible complications may include but are not limited to: Corneal Abrasion, Retinal detachment. This can cause loss of vision, but if detected early, corrective surgery is usually successful, Glaucoma, Characterized by increased pressure within the eye, this condition can usually be treated successfully, but can occasionally cause loss of vision. Pits or chips in the intraocular lens implant caused by improper focus of the laser. While this could not happen with conventional surgical posterior capsulotomy, the lens implant could be scratched or disclocated and any additional risks that may be discussed with you by your physician.

☐ **YAG Peripheral Iridotomy of the right eye**

☐ **YAG Peripheral Iridotomy of the left eye**

Possible complications may include but are not limited to: Corneal Abrasion, Retinal detachment. This can cause loss of vision, but if detected early, corrective surgery is usually successful. Glaucoma. Characterized by increased pressure within the eye, this condition can usually be treated successfully, but can occasionally cause loss of vision.

☐ **YAG Selective Laser Trabeculoplasty of the right eye**

☐ **YAG Selective Laser Trabeculoplasty of the left eye**

Possible complications may include but are not limited to: bleeding within the eye, inflammation, cataract and increase in the pressure in the eye requiring different and more extensive treatment. It will take several weeks to determine how much of your eye pressure will be lowered with this treatment. You may require additional laser surgery to lower the pressure if you have a response but one that is insufficient to control the pressure.

Anesthesia Types and Complications

☐ **Topical Anesthesia**

Possible complications with Topical Anesthesia include but are not limited to: Discomfort, stinging sensation during administration of topical eye drops.

I authorize the diagnostic procedure(s) and such other therapeutic procedure(s) which may be necessary, including, anesthesia care and pathology. I understand and agree that the person(s) administering anesthesia or performing other professional services, such as pathology and the like, are independent contractors and may not be employees or agents of the attending physician or the facility. I acknowledge and understand that the following procedure which has been described to me is to be performed at Valley Surgery Center (the "Facility"):

(A) Understanding of the Procedure: I understand the nature of the procedure, the expected benefits or effects of such procedure, the medically acceptable alternative procedures or treatments. I have a general understanding of the procedure to be performed on me. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

Chart Prepared By: _____

(B) Possible Risks of The Procedure(s): I understand and consent to the possible complication of the scheduled procedure as they have been explained to me.

(C) Consent for the Administration of Anesthesia: In addition to the foregoing, I consent to the administration of Anesthesia as required for the procedure. I understand and acknowledge that all forms of anesthesia involve some risks and the facility can make no guarantees or promises concerning the results or outcome of the anesthesia plan of care. I acknowledge that I have made arrangements to have a responsible person to drive me home after the administration of anesthesia. I acknowledge that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and I will avoid making decisions or taking in activities, which depend upon full concentration or judgment during this period. If you have ever had a severe allergic reaction to ANY substance or environment (including latex or a bee sting) you must tell your physician and the anesthesia provider before we give you medication or other substances. I understand the possible complication of the planned anesthesia care as they have been explained to me.

(D) Human Immunodeficiency Virus (HIV) and Hepatitis Testing: I understand that in the event a health care worker sustains a significant exposure to my blood or body fluids, I may be asked to undergo testing for HIV, (the virus that causes AIDS), and hepatitis. The results of any test will be confidential and will be treated in accordance with Indiana law. I understand that, in accordance with Indiana law, a positive HIV test result will be reported to the county health department with sufficient information to identify me. Furthermore, I hereby authorize the Valley Surgery Center and my physician to disclose such HIV test results to any third party payor, as appropriate for processing and payment.

(E) If a Physician Has Signed and Issued DNR (Do Not Resuscitate) Order For You: If I have consented to a do not resuscitate order ("DNR"), I understand and acknowledge that my consent to a DNR order is temporarily SUSPENDED while I undergo any procedure performed at this Facility. It is the policy of this center that, regardless of the contents of any advance directives/living will or instruction from a health care surrogate, patient representative, or attorney, the Center will always attempt to resuscitate and transfer you to an acute health care facility in the event of deterioration.

(F) Use/Disposal of Tissue: I hereby authorize the Facility to retain, photograph, preserve, dispose and submit for scientific or teaching purposes, or dispose of at its convenience any specimens or tissues taken from my body during my procedure or treatment. Specimens or tissues removed may be sent to a laboratory for further testing or examination by a pathologist.

(G) Consent for Transfer: I understand that the surgical and/or diagnostic procedure to be performed on me at the facility will be done on an outpatient basis and that the facility does not provide 24 hour patient care. If my attending physician or any other duly qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the facility to a hospital, then, I consent and authorize the employees of the facility to arrange the transfer. In an event of a hospital transfer, I consent to the surgery center obtaining a copy of my discharge summary from the hospital.

(H) Observation Consent: For medical, scientific or educational purposes, I consent to the admittance of approved observers to the procedure room and release of Valley Surgery Center and the attending physician from any liability that may arise from their presence in the procedure room.

(I) Photographs: I consent to the taking and publication of any photographs in the course of this operation for the purpose of treatment and/or medical education.

(J) Certification and Signatures: I certify that I understand the information regarding my procedure and the administration of anesthesia (if necessary) and that I have been fully informed of the risks and possible complications thereof, as well as, medically acceptable alternatives to my procedure. I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. I hereby authorize and permit the physician and whomever he/she may designate as his/her assistants to perform upon me the named procedure(s).

If any unforeseen condition arises during the procedure calling in his/her judgment for additional procedures or medications, I further request and authorize him/her to do whatever he/she deems advisable.

Patient Signature_____Date_____Time_____

Witness Signature_____Date_____Time_____