Consent Forms in Ophthalmic Practice

Editors

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Consent is an extremely important part of patient care system. Many legal battles are simply the result of failure to obtain a proper informed consent. There is a crucial difference between a consent and an informed consent. There is also a difference between a routine consent and a consent which the patient and his/her family understands and comprehends. Ideally, the patient should be given the consent form sufficiently prior to the procedure to let him read, discuss and decide. This manual is an initial attempt by the Delhi Ophthalmological Society to bring uniformity in medical practice amongst our fellow colleagues. We hope this would take care of an important felt need among practising ophthalmologists. This manual is intended to provide broad guidelines for obtaining consent in the commonly used procedures in ophthalmic practice and may be modified depending on individual requirements and circumstances. Any feedback or suggestions are welcome.

Bhavna Chawla
Namrata Sharma
Lalit Verma
Acknowledgments

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Disclaimer

This manual is for educational purpose only and is not intended to constitute legal advice. Hence it should not be relied upon as a source for legal advice.
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RETINA

Cryosurgery

Bipul Baishya, Atul Kumar

Name of Patient ................................ Age/Sex ........ Patient ID ......................... Date

Son / Daughter of

.............................................................................................................................................................
Proposed Treatment
The doctor has explained that I, (name of patient ……………….), have a retinal lesion in my……..eye which is a risk factor for development of ………………. and Cryosurgery is proposed.

Risks
These are the commoner risks. There may be other unusual risks that have not been listed here.

I understand there are risks associated with any anesthetic agent (in case of children).

I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand the procedure has the following specific risks and limitations:
1. Although most retinal lesions can be treated, it is not 100% effective. In some cases, more than two sittings may be required.
2. Corneal burns
3. Retinal detachment or macular puckering that may require additional surgery
4. Inflammation
5. Pigmentary disturbances
6. Bleeding in eye

Local complications of anesthesia injections around the eye include:
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

Individual Risks
I understand the following are possible significant risks and complications specific to my individual circumstances, that I have considered in deciding to have this operation:

Declaration by Patient
I acknowledge doctors from the ophthalmic team have informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
I acknowledge that I have discussed with the surgical team any significant risks and complications specific to my individual circumstances that I have considered in deciding to have this operation.

I understand that a doctor other than the specialist surgeon may perform the procedure.

I have received no guarantee the operation will be successful.

I have received a copy of this form to take home with me.

If a needle stick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders.

I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.

Signature / Thumb Impression of Patient/ Parent / Guardian:

..........................................................................................................................

Name: .............................................................. Relationship ......................... Date ..................................

Address:

..............................................................................................................................................................................

Phone (Off) .......................... (Res) ........................................ (Mob) ............................................................

Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1

Signature: ..............................................................

Name: ..............................................................

Address: ..............................................................

Tel: ..............................................................

Witness 2

Signature: ..............................................................

Name: ..............................................................

Address: ..............................................................

Tel: ..............................................................
Retinal Detachment

Bipul Baishya, Y.R. Sharma

Name of Patient ................................... ...........  Age/Sex ........ Patient ID .............................. Date

Son / Daughter of ............................................................................................................................................................

Address ........................................... ....................................................................................................

Proposed Treatment
The doctor has explained that I, (name of patient ..............................................), have a retinal detachment
in my....................eye and that..............................................is proposed:

Risks
These are the commoner risks. There may be other unusual risks that have not been listed here.

I understand there are risks associated with any anesthetic agent.

I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand the procedure has the following specific risks and limitations:
1. Although most retina detachments can be treated, a small proportion (5%) may be inoperable and blindness cannot be prevented.
2. Failure to accomplish intent of surgery
3. More than one surgery may be required. Like if Scleral buckling surgery fails, Vitrectomy may be required with Silicone Oil or Gas tamponade.
4. In case of Silicone Oil or Gas injection, I have to maintain position depending upon the surgery.
5. If Gas is injected, I have to restrict air travel until gas is absorbed.
6. If Silicone oil is injected, then resurgery will be required to remove the oil.
7. It may take up to 18 months before the final outcome of the surgery is known. Although many cases achieve a good result, this depends on several factors including how long the detachment had been present.
8. It may not be possible to predict before the operation which cases will do well.
9. There is a chance I may develop further retina detachments in future in the same eye or in the opposite eye.
10. In some cases, more than one operation may be required
11. Though rare, I may develop complications like vitreous hemorrhage, infection, elevated eye pressure (glaucoma), poorly healing or non-healing corneal defects, corneal clouding and scarring, cataract, which might require eventual or immediate removal of lens, double vision, eyelid droop, and loss of circulation to vital tissues in the eye, resulting in decrease or loss of vision

There is an extremely small risk (1:17000 cases) that the opposite eye to the one having surgery may become inflamed, especially if complications occur after the operation. This is called sympathetic ophthalmia. Although this can be treated, in some cases, eyesight may be lost.
I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

**Individual Risks**
I understand the following are possible significant risks and complications specific to my individual circumstances, that I have considered in deciding to have this operation:

..................................................................................................................................................................................

..................................................................................................................................................................................

..................................................................................................................................................................................

Declaration By Patient
I acknowledge doctors from the ophthalmic team have informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.

I acknowledge that I have discussed with the surgical team any significant risks and complications specific to my individual circumstances that I have considered in deciding to have this operation.

I agree to any other additional procedures considered necessary in the judgment of my surgeon during this operation.

I have received no guarantee the operation will be successful.

I have received a copy of this form to take home with me.

If a needle stick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders.

I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.

Signature / Thumb Impression of Patient/ Parent / Guardian:
..................................................................................................................................................................................

Name: .......................................................... Relationship ......................... Date ....................

Address:
..................................................................................................................................................................................

Phone (Off) ............................................ (Res) ........................................ (Mob) 

Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature
Vitreo Retinal Surgery

Bipul Baishya, R.V. Azad

Name of Patient ................................. Age/Sex ....... Patient ID ............................... Date 

Son / Daughter of .................................................................

Address ............................................................................. Tel

Proposed Treatment

The doctor has explained that I, (name of patient ………………..), have ……………….. in my ……………….. Eye and that……………………………..is proposed.

Risks

These are the commoner risks. There may be other unusual risks that have not been listed here.

I understand there are risks associated with any anesthetic agent.

I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand the procedure has the following specific risks and limitations:

1. Failure to accomplish intent of surgery
2. Retinal detachments that may require additional surgery or may be inoperable
3. Depending upon the surgery, Silicone Oil or Gas may be required for tamponade.
4. In case of Silicone Oil or Gas injection, I have to maintain position depending upon the surgery.
5. If Gas is injected, I have to restrict air travel until gas is absorbed.
6. If Silicone oil is injected then resurgery will be required to remove the oil.
7. It may take up to 18 months before the final outcome of the surgery is known.
8. In a few cases, the underlying condition cannot be treated and blindness cannot be prevented.
9. It may not be possible to predict before the operation which cases will do well.
10. There is a chance I may develop further retina detachments in future in the same eye or in the opposite eye.
11. In some cases, more than one operation may be required
12. Though rare I may develop complications like vitreous hemorrhage, infection, elevated eye pressure (glaucoma), poorly healing or non-healing corneal defects, corneal clouding and scarring, cataract, which might require eventual or immediate removal of lens, double vision, eyelid droop, and loss of circulation to vital tissues in the eye, resulting in decrease or loss of vision.

There is an extremely small risk (1:17000 cases) that the opposite eye to the one having surgery may become inflamed, especially if complications occur after the operation. This is called sympathetic ophthalmia. Although this can be treated, in some cases, eyesight may be lost.

I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

**Individual Risks**

I understand the following are possible significant risks and complications specific to my individual circumstances, that I have considered in deciding to have this operation:

...........................................................................................................................................................................

...........................................................................................................................................................................

...........................................................................................................................................................................

**Declaration by Patient**

I acknowledge doctors from the ophthalmic team have informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.

I acknowledge that I have discussed with the surgical team any significant risks and complications specific to my individual circumstances that I have considered in deciding to have this operation.

I agree to any other additional procedures considered necessary in the judgment of my surgeon during this operation.

I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.

I have received no guarantee the operation will be successful.

I have received a copy of this form to take home with me.

If a needle stick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders.

I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.

Signature / Thumb Impression of Patient/ Parent / Guardian: ............................................................

Name: ............................................................  Relationship ............................ Date ..............................
Address: ..................................................................................................................................................................................

Phone (Off) ....................................... (Res) .......................................... (Mob)
..................................................................................................................................................................................

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

<table>
<thead>
<tr>
<th>Witness 1</th>
<th>Witness 2</th>
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<td>Name: ........................................</td>
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<td>Address: ........................................</td>
<td>Address: ........................................</td>
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<td>Tel: ........................................</td>
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**Macular Hole Surgery**

*Ritesh Gupta*

Name of Patient ................................... ...........  Age/Sex ........ Patient ID ........ ...................... Date ............

Son / Daughter of ..........................................................

Address ..........................................................

Tel. ..........................................................

**Indications and Benefits**

Your doctor has diagnosed you with macular hole and informed you that if it is left untreated, it is likely that you will have gradual central vision deterioration but you will not lose all of the vision in your eye.
Your doctor has informed you that a procedure involving pars plana vitrectomy with/without internal limiting membrane removal and gas injection will be performed in your eye under local/general anesthesia. The important factors in predicting whether the hole closes as a result of surgery is the duration for which the hole has been present and the size of the hole. The success rate for holes that have been present for less than six months is about 90%. However, this reduces to around 60% for a hole which has been present for a year or more. Your doctor has told you that a successful macular hole closure does not guarantee complete visual recovery and that a 2-line improvement is usually the measure of success of the surgery. You have been told that postoperative positioning also has an important role to play for closure of macular hole and that a good majority of the failures stem from incomplete and inconsistent postoperative positioning.

**Complications**

As with any surgical procedure, there are risks associated with macular hole surgery. Not every conceivable complication can be covered in this form but the following are examples of risk encountered with macular hole surgery. These complications can occur days, weeks, months, or years later. They can result in loss of vision or blindness. Careful follow-up is required after surgery.

**Complications of the surgery**

1. Failure to accomplish closure of the hole (10-40% depending primarily on the duration and size)
2. Retinal detachments that may require additional surgery or may be inoperable (1-2%)
3. Vitreous hemorrhage
4. Infection (0.02%-0.1%)
5. Elevated eye pressure (glaucoma)
6. Cataract, which might require eventual or immediate removal of lens
7. Poorly healing or non-healing corneal defects
8. Corneal clouding and scarring

**Complications of anesthesia injections around the eye**

1. Perforation of eyeball
2. Needle damage to the optic nerve, which could destroy vision
3. Retrobulbar hemorrhage
4. Possible drooping of eyelid
5. Systemic effects that have the potential for life-threatening complications and death

**Patient Consent**

In spite of the risks noted above, I understand that there is more risk to my vision if I do not have the operation than if I do. I have read and understand the consent form, I have had my questions answered, and I authorize my surgeon to proceed with the operation on my ................................ (indicate “right” or “left” eye).

Signature / Thumb Impression of Patient/ Parent / Guardian: ........................................................................................................................................................................................................................................

Name: ........................................................................................................................................................................................................................................ Relationship

.................................................. Date .........................................

Address: ........................................................................................................................................................................................................................................

Phone (Off) ............................................................... (Res) ........................................... (Mob)
........................................................................................................
Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ......................................................
Name: .............................................................
Address: ........................................................
Tel: ...............................................................

Witness 2
Signature: ......................................................
Name: .............................................................
Address: ........................................................
Tel: ...............................................................

Avastin™ Intraivtreal Injection

Zahir Abbas, Gunjan Prakash

Name of Patient ....................................... Age/Sex ........ Patient ID .................. Date ..................

Son / Daughter of ........................................................................................................................................................................

Address ........................................................................................................................................................................Tel. ........................................................................

Possible Benefits and “Off-Label” Status

Avastin™ was not initially developed to treat your eye condition. Based upon the results of clinical trials that demonstrated its safety and effectiveness, Avastin™ was approved by the Food and Drug Administration (FDA) for the treatment of metastatic colorectal cancer. Once a device or medication is approved by the FDA, physicians may use it “off-label” for other purposes if they are well-informed about the product, base its use on firm scientific method and sound medical evidence, and maintain records of its use and effects. Ophthalmologists are using Avastin™ “off-label” to treat AMD and similar conditions since research indicates that VEGF is one of the causes for the growth of the abnormal vessels that cause these conditions. Some patients treated with Avastin™ had less fluid and more normal-appearing maculas, and their vision improved. Avastin™ is also used, therefore, to treat macular edema, or swelling of the macula. Recently, a medication
similar in function and designed for intravitreal administration was approved by the FDA for the treatment of AMD.

**Possible Limitations**
The goal of treatment is to prevent further loss of vision. Although some patients have regained vision, the medication may not restore vision that has already been lost, and may not ultimately prevent further loss of vision caused by the disease.

**Alternatives**
You do not have to receive treatment for your condition, although without treatment, these diseases can lead to further vision loss and blindness, sometimes very quickly. Other forms of treatment are available. At present, there are three FDA-approved treatments for neovascular age-related macular degeneration. The first two are photodynamic therapy with a drug called Visudyne™ and injection into the eye of a drug called Macugen™. The third medication, Lucentis™ is similar to Avastin™. In addition to the FDA-approved medications, some ophthalmologists use intravitreal triamcinolone —“off-label” to treat eye conditions like yours.

**Complications when Avastin™ is given to patients with cancer**
When Avastin™ is given to patients with metastatic colorectal cancer, some patients experienced gastrointestinal perforations or wound healing complications, hemorrhage, arterial thromboembolic events (such as stroke or heart attack), hypertension, proteinuria, and congestive heart failure. Patients who experienced these complications not only had metastatic colon cancer, but were also given 400 times the dose you will be given, at more frequent intervals, and in a way (through an intravenous infusion) that spread the drug throughout their bodies.

**Risk when Avastin™ is given to treat patients with eye conditions**
The risk of these complications for patients with eye conditions is low. Patients receiving Avastin™ for eye conditions are healthier than the cancer patients, and receive a significantly small dose, delivered only to the cavity of their eye. While there are no FDA-approved studies about the use of Avastin™ in the eye that prove it is safe and effective, Lucentis™, a similar drug, was recently approved for AMD. One study of patients who received Avastin™ through an intravenous infusion reported only a mild elevation in blood pressure. Another study of patients treated like you will be with intravitreal Avastin™ did not have these elevations or the other serious problems seen in the patients with cancer. However, the benefits and risks of intravitreal Avastin™ for eye conditions are not yet fully known. In addition, whenever a medication is used in a large number of patients, a small number of coincidental life-threatening problems may occur that have no relationship to the treatment. For example, patients with diabetes are already at increased risk for heart attacks and strokes. If one of these patients being treated with Avastin™ suffers a heart attack or stroke, it may be caused by the diabetes and not the Avastin™ treatment.

**Known risks of intravitreal eye injections**
*Your condition may not get better or may become worse. Any or all of these complications may cause decreased vision and/or have a possibility of causing blindness.* Additional procedures may be needed to treat these complications. Possible complications and side effects of the procedure and administration of Avastin™ include but are not limited to retinal detachment, cataract formation, glaucoma, hypotony (reduced pressure in the eye), damage to the retina or cornea, and bleeding. There is also the possibility of an eye infection (endophthalmitis). Any of these rare complications may lead to severe, permanent loss of vision.

**Patient Responsibilities**
I will immediately contact my doctor if any of the following signs of infection or other complications develop: pain, blurry or decreased vision, sensitivity to light, redness of the eye, or discharge from the eye. I will keep all post-injection appointments so my doctor can check for complications.

Although the likelihood of serious complications affecting other organs of my body is low, I will immediately contact my physician if I experience abdominal pain associated with constipation & vomiting, abnormal
bleeding, chest pain, severe headache, slurred speech, or weakness on one side of the body. As soon as possible, I will also notify the treating ophthalmologist of these problems.

I will inform any other surgeon that I am on a medication that needs to be stopped before I can have surgery.

**Patient Consent**

The above explanation has been read by/to me. The nature of my eye condition has been explained to me and the proposed treatment has been described. The risks, benefits, alternatives, and limitations of the treatment have been discussed with me. *All my questions have been answered.*

I understand that Avastin™ was approved by the FDA for the treatment of metastatic colorectal cancer, and has not been approved for the treatment of eye conditions. Nevertheless, I wish to be treated with Avastin™, and I am willing to accept the potential risks that my physician has discussed with me. I hereby authorize the treating eye-surgeon to administer the intravitreal Avastin™ in my affected eye as needed. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this medication for me are significantly different.

Signature / Thumb Impression of Patient/ Parent / Guardian:

...............................................................................................................................................
Name: .................................................................................................................. Relationship
.................................................................. Date .........................
Address:
........................................................................................................................................
..........................
Phone (Off) ............................................................... (Res) ........................................... (Mob)
..........................................................................................

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: ............................................ Name: ..............................................
Address: ............................................ Tel: ..............................................

**Witness 2**

Signature: ............................................ Name: ..............................................
Address: ............................................ Tel: ..............................................
Macugen™ Intravitreal Injection

Aparna Gupta

Name of Patient ........................................... Age/Sex .......... Patient ID .................................. Date ..............................................

Son / Daughter of ............................................................................................................................................................

Address ........................................... ............................................................................................................................................................ Tel. ..........................................................

Indications
Macugen is used to treat adults with an eye problem called the wet form (neovascular) of age-related macular degeneration.  Macular degeneration causes vision loss leading to blindness.

Contraindications
Do not use Macugen if you have an infection in or around your eye

Possible Limitations
The goal of treatment is to prevent further loss of vision.  Although some patients have regained vision, the medication may not restore vision that has already been lost, and may not ultimately prevent further loss of vision caused by the disease.

Alternatives
You do not have to receive treatment for your condition, although without treatment, these diseases can lead to further vision loss and blindness, sometimes very quickly. Other forms of treatment are available.  At present, there are three FDA-approved treatments for neovascular age-related macular degeneration.  The first is photodynamic therapy with a drug called Visudyne™.  The other two are injection into the eye of Macugen™ and Lucentis™.  In addition to the FDA-approved medications, some ophthalmologists use intravitreal Avastin™ and triamcinolone —“off-label” to treat eye conditions like yours.

Side Effects
The most common side effects with Macugen include:

1. inflammation of the eye
2. blurred vision or changes in vision
3. cataracts
4. bleeding in the eye
5. swelling of the eye
6. eye discharge
7. irritation or discomfort of the eye
8. eye pain
9. seeing “spots” in your vision

Patient Responsibilities
I will inform my doctor if I’m pregnant, planning to conceive or breast feeding.
I will immediately contact my doctor if any of the following signs of infection or other complications develop: pain, blurry or decreased vision, sensitivity to light, redness of the eye, or discharge from the eye. I will keep all my post-injection appointments so that my doctor can check for complications.

Although the likelihood of serious complications affecting other organs of my body is low, I will immediately contact my physician if I experience abdominal pain associated with constipation & vomiting, abnormal bleeding, chest pain, severe headache, slurred speech, or weakness on one side of the body. As soon as possible, I will also notify the treating ophthalmologist of these problems.

I will inform any other surgeon that I am on a medication that needs to be stopped before I can have surgery.

**Patient Consent**

The above explanation has been read by/to me. The nature of my eye condition has been explained to me and the proposed treatment has been described. The risks, benefits, alternatives, and limitations of the treatment have been discussed with me. *All my questions have been answered.*

I understand that Macugen™ was approved by the FDA for the treatment of metastatic colorectal cancer, and has not been approved for the treatment of eye conditions. Nevertheless, I wish to be treated with Macugen™, and I am willing to accept the potential risks that my physician has discussed with me. I hereby authorize the treating eye-surgeon to administer the intravitreal Macugen™ in my affected eye as needed. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this medication for me are significantly different.

**Signature / Thumb Impression of Patient/ Parent / Guardian:**

Name: ................................................................. Relationship ............................................ Date ..................................

Address: ...........................................................................................................................................................

Phone (Off) ............................................................... (Res) ................................................................. (Mob)

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date
Lucentis™ Intravitreal Injection

Aparna Gupta

Name of Patient ...........................................  Age/Sex ..........  Patient ID ......................  Date .....................

Son / Daughter of ...........................................................................................................................................

Address ..........................................................................................................................................................  Tel. ................................................................

Indications
Lucentis is used to treat adults with an eye problem called the wet form (neovascular) of age-related macular degeneration. Macular degeneration causes vision loss leading to blindness.

Contraindications
Do not use Lucentis if you have an infection in or around your eye.

Possible Limitations
The goal of treatment is to prevent further loss of vision. Although some patients have regained vision, the medication may not restore vision that has already been lost, and may not ultimately prevent further loss of vision caused by the disease.

Alternatives
You do not have to receive treatment for your condition, although without treatment, these diseases can lead to further vision loss and blindness, sometimes very quickly. Other forms of treatment are available. At present, there are three FDA-approved treatments for neovascular age-related macular degeneration. The first is photodynamic therapy with a drug called Visudyne™. The other two are injection into the eye of Lucentis™ and Macugen™. In addition to the FDA-approved medications, some ophthalmologists use intravitreal Avastin™ and triamcinolone — “off-label” to treat eye conditions like yours.

Side Effects
The most common side effects with Lucentis include:
1. Inflammation of the eye
2. Blurred vision or changes in vision
3. Cataracts
4. Bleeding in the eye
5. Swelling of the eye
6. Eye discharge
7. Irritation or discomfort of the eye
8. Eye pain
9. Seeing “spots” in your vision
10. The most common non–eye-related side effects were high blood pressure, nose and throat infection, and headache.
11. Although uncommon, conditions associated with eye- and non–eye-related blood clots (arterial thromboembolic events) may occur.

Patient Responsibilities
I will inform my doctor if I’m pregnant, planning to conceive or breast feeding.

I will immediately contact my doctor if any of the following signs of infection or other complications develops: pain, blurry or decreased vision, sensitivity to light, redness of the eye, or discharge from the eye. I will keep all my post-injection appointments so that my doctor can check for complications.

Although the likelihood of serious complications affecting other organs of my body is low, I will immediately contact my physician if I experience abdominal pain associated with constipation & vomiting, abnormal bleeding, chest pain, severe headache, slurred speech, or weakness on one side of the body. As soon as possible, I will also notify the treating ophthalmologist of these problems.

I will inform any other surgeon that I am on a medication that needs to be stopped before I can have surgery

Patient Consent
The above explanation has been read by/to me. The nature of my eye condition has been explained to me and the proposed treatment has been described. The risks, benefits, alternatives, and limitations of the treatment have been discussed with me. All my questions have been answered.

I understand that Lucentis™ was approved by the FDA for the treatment of metastatic colorectal cancer, and has not been approved for the treatment of eye conditions. Nevertheless, I wish to be treated with Lucentis™, and I am willing to accept the potential risks that my physician has discussed with me. I hereby authorize the treating eye-surgeon to administer the intravitreal Lucentis™ in my affected eye as needed. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this medication for me are significantly different.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1

Signature: ......................................................
Name: ...........................................................
Address: ......................................................
Tel: ..............................................................

Witness 2

Signature: ......................................................
Name: ...........................................................
Address: ......................................................
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ROP Laser

Parijat Chandra

Name of Patient ........................................... Age/Sex .......... Patient ID ......................... Date
Son / Daughter of ............................................................................................................................
Address ................................................................. Tel.

I have been informed in my mother tongue that my child’s eye(s) are affected with the disease Retinopathy of Prematurity (ROP) which urgently requires retinal laser photocoagulation treatment.

I have been fully explained regarding Retinopathy of Prematurity, its vision blinding complications, and the urgent necessity for retinal laser treatment. I have been clearly explained about the laser procedure, its side effects and risks involved. I understand that depending on disease severity and treatment response, additional laser treatments may be required later. I understand that despite the best of laser treatment, sometimes the disease may progress leading to visually disabling sequelae and blindness, and later may require surgical intervention which may or may not be beneficial.
I allow the attending neonatologist to administer drugs, infusions or any other treatment/procedures as deemed necessary or desirable during the laser procedure (and in any unforeseen or emergency conditions they encounter).

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform retinal laser photocoagulation on my child’s right/left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian: .................................................................

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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: .................................................................
Name: ..............................................................................
Address: .................................................................
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Witness 2
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Laser Indirect Ophthalmoscopy
This document is intended to provide you with information so that you can decide whether you should have a type of laser surgery called laser indirect ophthalmoscopy or LIO. You have the right to ask any questions you might have about the procedure before agreeing to have the ophthalmologist, or eye surgeon, perform it on your eye.

**Indications for Laser Indirect Ophthalmoscopy**

The eye functions much like a camera. The front of the eye contains the structures which focus the image and regulate the amount of light that enters the eye, similar to the lens and shutter of a camera. In the back of the eye is the retina, which functions like the film in the camera. Without film, a camera cannot take a picture, and without a functioning retina, the eye cannot see.

LIO is done to laser the peripheral retina. It is used to treat peripheral retinal lesions like lattice degeneration or a retinal break, which may predispose your eyes to retinal detachment. LIO is also done to delimit peripheral detached retina to prevent its further progression. LIO can also be used for augmentation of pan-retinal photocoagulation where the peripheral retina cannot be lasered by using a slit lamp machine.

**Possible Benefits of Laser Indirect Ophthalmoscopy**

Laser indirect ophthalmoscopy or LIO uses a laser to treat the peripheral retina so that it will form a strong adhesion of the retina with underlying layers, preventing the retina to detach, and avoiding a potentially blinding condition.

To perform the procedure, the pupil of the eye is made bigger (dilated) with eye drops. The laser is aimed at the peripheral retina through the pupil with the help of an indirect ophthalmoscope. Since the laser treats the peripheral retina, some peripheral or side vision may be lost, and this may cause reduced night vision. This usually does not present a problem for most of the cases.

**Alternatives to Laser Indirect Ophthalmoscopy**

Cryotherapy has also been used to treat peripheral retinal lesions. Cryotherapy uses a probe placed against the outside of the eye to treat the peripheral retina by freezing it. Most ophthalmologists now treat the peripheral retina with a laser instead of cryotherapy.

**Risks and Complications of Laser Indirect Ophthalmoscopy**

When deciding whether or not to have surgery, the patient must weigh the possible risks of the surgery against the benefits the surgery is expected to produce. Laser surgery for peripheral retina has limited risks. While performing the surgery, structures of the eye can be damaged and cause complications, which may lead to loss of vision. Surgery or medications may be needed to treat these complications.

In the majority of patients whose eyes were treated with LIO, the retina remained attached. While the goal of the surgery is prevent a retinal detachment and blindness, even with proper treatment, not all eyes respond to the treatment. New lesions of the retina may develop and regular retinal screening is required. For some the laser surgery may have to be repeated in order to completely treat the retinal lesion.

Risks for LIO include, but are not limited to:
1. Failure to achieve the goal of surgery: even with treatment, retinal detachment may develop in few cases.
2. Bleeding in the eye (vitreous hemorrhage)
3. Elevated eye pressure (glaucoma)
4. Decreased eye pressure (hypotony)
5. Corneal burns (clear covering of the front of the eye)
6. Damage to the iris (colored portion of the eye)
7. Damage to the lens (cataract)
8. Loss of vision or loss of the eye
9. Loss of peripheral (side) vision
10. Corneal clouding or scarring
11. Decrease or loss of vision caused by loss of circulation to the vital tissues in the eye

Consent for Laser Surgery for ROP

The ophthalmologist has explained to me the problem with my eyes, and the risks, benefits, and alternatives to LIO surgery. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction. I understand that there is no guarantee that the surgery will prevent blindness in my eye, and that the surgery may need to be repeated to effectively treat my condition.

In signing this informed consent for LIO, I am stating that I have been offered a copy and I fully understand the possible risks, benefits, and complications of the laser surgery.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name
Laser Photocoagulation for Diabetic Retinopathy

Aparna Gupta

This document is intended to provide you with information so that you can decide whether you should have Laser photocoagulation for diabetic retinopathy.

You have the right to ask any questions you might have about the procedure before agreeing to have the ophthalmologist, or eye surgeon, perform it on your eye.

**Indications for Laser Photocoagulation for Diabetic Retinopathy**

The eye functions much like a camera. The front of the eye contains the structures which focus the image and regulate the amount of light that enters the eye, similar to the lens and shutter of a camera. In the back of the eye is the retina, which functions like the film in the camera. Without film, a camera cannot take a picture, and without a functioning retina, the eye cannot see.

Laser photocoagulation uses the heat from a laser to seal or destroy abnormal, leaking blood vessels in the retina. One of two approaches may be used when treating diabetic retinopathy:

- **Focal photocoagulation.** Focal treatment is used to seal specific leaking blood vessels in a small area of the retina, usually near the macula. The ophthalmologist identifies individual blood vessels for treatment and makes a limited number of laser burns to seal them off.

- **Scatter (pan-retinal) photocoagulation.** Scatter treatment is used to slow the growth of new abnormal blood vessels that have developed over a wide area of the retina. The ophthalmologist may make hundreds of laser burns on the retina to stop the blood vessels from growing. The person may need two or more treatment sessions.
Laser photocoagulation is not painful. The injection of anesthetic may be uncomfortable, and you may feel a slight stinging sensation or see brief flashes of light when the laser is applied to your eye.

**Possible Benefits of Laser Photocoagulation for Diabetic Retinopathy**

Laser treatment may not restore vision that has already been lost. But when performed in a timely manner,

- Focal photocoagulation, which targets specific blood vessels, is effective in reducing the risk of vision loss in people with macular edema. It lowers the risk of moderate vision loss by 20% in people who have mild to moderate non-proliferative retinopathy. It may also help prevent progression to more severe retinopathy.

- Scatter (pan-retinal) photocoagulation, which treats a wide area of the retina, reduces the risk for severe vision loss by 50% to 60% over 6 years in people with a high risk of vision loss. It reduces the risk of serious bleeding and progression of severe proliferative retinopathy and the need for surgery (vitrectomy) by 50% in people with type 2 diabetes and people age 40 and older with type 1 diabetes who already have severe non-proliferative or mild proliferative retinopathy. Studies suggest that up to 90% of cases of legal blindness caused by proliferative retinopathy could be prevented by prompt scatter photocoagulation.

**Risks and Complications of Laser Photocoagulation for Diabetic Retinopathy**

Laser photocoagulation burns and destroys part of the retina and often results in some permanent vision loss. This is usually unavoidable. Treatment may cause mild loss of central vision, reduced night vision, and decreased ability to focus. Some people may lose some of their side (peripheral) vision. However, the vision loss caused by laser treatment is mild compared with the vision loss that may be caused by untreated retinopathy.

Rare complications of laser photocoagulation may cause severe vision loss. These include:

- Bleeding in the eye (vitreous hemorrhage).
- Traction retinal detachment.
- Accidental laser burn of the fovea (a depression in the central macula that contains no blood vessels), resulting in severe central vision loss.

**Consent for Laser Photocoagulation for Diabetic Retinopathy**

The ophthalmologist has explained to me the problem with my eyes, and the risks, benefits, and alternatives to laser photocoagulation. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction. I understand that there is no guarantee that the laser will prevent blindness in my eye, and that the laser may need to be repeated to effectively treat my condition.

In signing this informed consent for laser photocoagulation, I am stating that I have been offered a copy and I fully understand the possible risks, benefits, and complications of the laser surgery.

Signature / Thumb Impression of Patient/ Parent / Guardian: ........................................................................................................................................................................

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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: ......................................................
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**Witness 2**

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**Laser Photocoagulation for Proliferative Retinopathy**

*Courtesy: Shroff Eye Centre, New Delhi*

Name of Patient ...........................................  Age/Sex ........ Patient ID .................. Date

Son / Daughter of

Address .......................................................... Tel.

I hereby authorize Dr. ...................................................... to perform upon me Laser Photocoagulation in the Right / Left eye. The aim of this treatment is to decrease the risk of severe visual loss by preventing development of or promoting regression or shrinkage of abnormal retinal blood vessels.

I acknowledge that I understand that:

1. I have been diagnosed to have ..................................................
2. This treatment is usually indicated when it is likely that bleeding inside the eye from new abnormal blood vessels can occur. Sometimes laser photocoagulation may be indicated to prevent the development of new blood vessels. The intent of treatment is to reduce likelihood of hemorrhage and/or retinal detachment that could cause severe and possible permanent loss of vision. However hemorrhage and/or retinal detachment can occur despite laser treatment.

3. This treatment is not designed to improve my vision, only to stabilize it. In fact, it may make the vision somewhat worse. For example, the treatment may diminish my night vision and side vision to some extent. There is a 5% to 10% chance that it will diminish my reading vision as well.

4. No safer alternative exists to reduce the likelihood of losing vision. If treatment is not carried out. I understand that there is an increased risk of permanent vision loss from bleeding and scar tissue formation inside the eye.

5. Application of Cryo in Proliferative Vascular Retinopathy. In some cases of Diabetic Retinopathy or Eales Disease inspite of good photocoagulation, there can be neovascularization or recurrent Vitreous Hemorrhage. Hence, to ablate peripheral retina, Cryotherapy is used to avoid further problems.

6. Laser treatment may be carried out in one or several treatment sessions depending on the severity and extent of the new vessels and my tolerance for the treatment. When a peribulbar or retrobulbar Injection is given for local anesthesia, there is an extremely small chance of ocular penetration.

7. After treatment, periodic re-examination is necessary to monitor the response to treatment and detect any changes in the status of the retinopathy, especially any change that would require additional treatment. I understand that it is the patient’s responsibility to maintain follow up appointments necessary after laser treatment.

I acknowledge that the nature and the purpose of this procedure, the risks involved, alternatives and possible complications have been explained to me by my doctor and that all my questions have been answered to my satisfaction. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee can be made as to the results that may be obtained. All this has been explained to me in the language I understand.

I have read, or had read to me, the above information and I consent to treatment, recognizing the potential risks that are involved.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.
Laser Photocoagulation for Maculopathy

Courtesy: Shroff Eye Centre, New Delhi

I hereby authorize Dr. ............................................................... to perform upon me Laser Photocoagulation in the Right / Left eye for changes in the Macula (which is the vital region of the retina for clear central vision) caused by Diabetes / Age Related Macular Degeneration / Venous Blocks /

In diabetes / venous blocks the aim of treatment is to close the blood vessels and capillary abnormalities which leak fluid and cause water logging seen in this region. In age related macular degeneration the purpose is to destroy sub retinal neovascular membrane.

Following photocoagulation it is possible that there may be a slight improvement and you may be able to read a line or two more on the vision test chart. Laser photocoagulation helps in maintaining your existing vision and to a certain extent prevents worsening at a later date. In some instances vision may worsen despite photocoagulation due to unavoidable changes developing in this region.

In case of age - related macular degeneration, if the laser has to be applied to the centre of macula or very close to it, there can be an immediate drop of vision. In these cases, long term visual prognosis is better if laser is
done. When a peribulbar or retrobulbar injection is given for local anesthesia there is an extremely small chance of ocular penetration.

One or more sessions of laser may be required. During follow up, more photocoagulation may have to be done for changes in the macula or for other changes that might have developed during this period.

After treatment, periodic re-examination is necessary to monitor the response to treatment and detect any changes in the status of the retinopathy, especially any change that would require additional treatment. I understand that it is the patient’s responsibility to maintain follow up appointment necessary after laser treatment. I acknowledge that the nature and the purpose of this procedure, the risks involved, alternatives and the possible complications have been explained to me by my doctor, that all my questions, if any, have been answered to my satisfaction. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee can be made as to the results that may be obtained. All this has been explained to me in the language I understand.

I have read, or had read to me, the above information and I consent to treatment, recognizing the potential risks that are involved.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

**Witness 2**
Fundus Fluorescein Angiography / Ophthalmoscopy / Indocyanine Green Angiography

Courtesy: Shroff Eye Centre, New Delhi

Name of Patient ........................................... Age/Sex .......... Patient ID ............................. Date
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Son / Daughter of
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Address .............................................................. Tel.
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This investigation procedure comprises of injection of a dye- fluorescein or Indocyanine green into one of your veins in the arm and either taking rapid serial photographs of its passage within the inner structures of the eye, the retina and choroid or examining the inside of your eye with an instrument called the indirect ophthalmoscope with appropriate filters. The information obtained from a study of this procedure aids your doctor in either making a diagnosis, planning your treatment or assessing the results of treatment particularly photocoagulation. There is no discomfort from this test apart from the needle prick and the flash of the camera which is harmless. You may have nausea (sensation of vomiting) a minute or so after the injection. This usually passes off in about 30 seconds. Remaining calm and breathing deeply helps in overcoming this difficulty. You are advised to be on an empty stomach three hours prior to this test. Your usual diet can be taken soon after the procedure. Fluorescein is a highly non toxic drug and only rarely produces a mild allergic reaction which responds rapidly to appropriate medication. Serious life threatening reactions are exceptionally rare but can however occur. This is not different from what can occur with any other medication. The skin and urine stain yellow for about 36 hours with fluorescein and is of no consequence. You must be accompanied by an adult attendant during this test.

Informed Consent

The pamphlet on Fundus Fluorescein Angiography / Ophthalmoscopy / Indocyanine Green Angiography has been read by me/ out to me and having understood the content, I give my consent to the performance of this on me.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ......................................................................................................................................................... Relationship
.................................................................................. Date ..........................................................
Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: .................................................. Name: .......................................................... Address: .......................................................... Tel: ..........................................................

Witness 2
Signature: .................................................. Name: .......................................................... Address: .......................................................... Tel: ..........................................................

Photodynamic Therapy (PDT)

Courtesy: Shroff Eye Centre, New Delhi

Name of Patient ................................. Age/Sex ....... Patient ID .......................... Date

Son / Daughter of

Address  ..........................................................................................................................................................................................................................................

Tel. ..........................................................................................................................................................................................................................................

I hereby authorize Dr................................................. to perform upon me Photodynamic Therapy (PDT) in Right/Left eye for neovascular changes in the Macula (which is the vital region of the retina for clear central vision) caused by Age Related Macular Degeneration / Pathologic Myopia/other causes.

Photodynamic Therapy (PDT) is a type of laser therapy designed for the treatment of subretinal new-vessel formation especially when these new vessels involve the subfoveal region. These new vessels most commonly develop in i) Aging Macular Degeneration ii) Myopia, iii) Post inflammatory and iv) Idiopathic causes. When the fovea (the vital region of the retina for fine central reading and colour vision) is not involved, these vessels
can be destroyed by laser photocoagulation. However there is also simultaneous destruction of the retinal cells overlying these abnormal new vessels. This loss of function of retinal cells is usually acceptable in other areas but not at the fovea. Hence the search for alternative therapies which can destroy these abnormal vessels without destroying the overlying foveal retinal cells. The various alternatives tried for this are:

1) Surgery 2) Photodynamic Therapy (PDT) 3) TTT 4) Radiation 5) Anti-angiogenic factors.

1. Surgery : Results especially in Aging Macular Degeneration have been poor because in removing the membrane retinal pigment epithelial cells are also lost and vision usually does not improve. There is also a risk of significant vision loss if complications occur.

2. Photodynamic Therapy : Verteporfin “Visudyne” dye is injected into a vein in the arm and after that a contact lens is placed on the eye and laser treatment is applied to the area of neovascularization. After the treatment the entire body has to be protected from sunlight and strong light. For a few hours after treatment you will have blurred vision because of drops and the laser light exposure. Treatment results have been encouraging.

Most patients have stabilization of vision. A very small number may have actual improvement in vision. Some patients may experience reduction in central vision after the treatment. PDT treatment may need to be repeated depending on the progress seen on follow up examinations and fluorescein/indocyanine green angiograms/OCT results.

3. Radiation - Results have not been encouraging.
4. Anti-angiogenic factors :- Definitive results are not available so far.
5. Trans Pupillary Thermo Therapy:- Large spot of diode laser 810 nm with relatively low energy is applied to the area of new-vessels. This therapy has shown encouraging results in some cases, especially occult new-vessels.

You do not have to agree to have this therapy and, if you wish, we will continue to monitor your progress even if you choose not to try Photodynamic Therapy (PDT).

**Post-Treatment Regime**

After treatment you should not bend down and lift weights, and you should sleep with head up with 2 pillows. You must not be exposed to sunlight and very bright light as mentioned earlier.

After treatment, periodic re-examination is necessary to monitor the response to treatment and detect any changes in the status of the retinopathy, especially any change that would require additional treatment. I understand that it is the patient’s responsibility to maintain follow up appointments necessary after laser treatment. I acknowledge that the nature and the purpose of this procedure, the risks involved, alternatives and the possible complications have been explained to me and that all my questions, if any, have been answered to my satisfaction. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee can be made as to the results that may be obtained. All this has been explained to me in the language I understand.

I have read, or had read to me, the above information, and I consent to treatment, recognizing the potential risks that are involved.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
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Witness 2
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Trans Pupillary Thermotherapy (TTT)

Courtesy: Shroff Eye Centre, New Delhi

Name of Patient ........................................... Age/Sex ........ Patient ID ......................... Date
Son .......................................................................................................................... Daughter
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Son ..........................................................................................................................
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I hereby authorize Dr. ............................................................. to perform upon me Trans-Pupillary Thermotherapy in Right / Left eye for neovascular changes in the Macula (which is the vital region of the retina for clear central vision) caused by Age Related Macular Degeneration / Pathologic Myopia / other causes .............................................................

Transpupillary thermotherapy (TTT) is a type of laser therapy designed for the treatment of sub retinal new-vessel formation especially when these new vessels involve the subfoveal region. These new vessels most commonly develop in i) Aging Macular Degeneration ii) Myopia, iii) Post inflammatory and iv) Idiopathic causes. TTT is also used in the treatment of certain tumours. When the fovea (the vital region of the retina for fine central reading and colour vision) is not involved, these vessels can be destroyed by laser photocoagulation. However there is also simultaneous destruction of the retinal cells overlying these abnormal new vessels. This loss of function of retinal cells is usually acceptable in other areas but not at the fovea. Hence the search for alternative therapies which can destroy these abnormal vessels without destroying the overlying foveal retinal cells. The various alternatives tried for this are:-

1) Surgery 2) Photodynamic therapy (PDT) 3) TTT 4) Radiation 5) Anti-angiogenic factors.

1. Surgery : Results especially in Aging Macular Degeneration have been poor because in removing the membrane retinal pigment epithelial cells are also lost and vision usually does not improve. There is also a risk of significant vision loss if complications occur.

2. Photodynamic Therapy : This is applicable only to certain specific types of new-vessels. The cost of treatment is very high because of high cost of dye. The treatment may need to be repeated depending on the progress seen on follow up examinations.

3. Radiation - Results have not been encouraging.

4. Anti-angiogenic factors : Results have not been encouraging.

5. Trans Pupillary Thermo Therapy :- Large spot of diode laser 810 nm with relatively low energy is applied to the area of new-vessels. Treatment results have been encouraging. About two-thirds of patients have stabilization of vision. A very small number may have actual improvement in vision. Some patients may experience reduction in central vision after the treatment. TTT treatment may need to be repeated depending on the progress seen on follow up examinations and fluorescein/indocyanine green angiograms.

For the laser treatment, local anaesthetic drops are put into the eye and a contact lens is used. After treatment you should not bend down, lift weight and you should sleep with head up with 2 pillows. For a few hours after the treatment, you will have some blurred vision because of the drops used to prepare your eye for the treatment. You should also wear dark sunglasses to protect your eye from the light. During this time, you must not drive any vehicles. You do not have to agree to have this therapy and, if you wish, we will continue to monitor your progress even if you choose not to try Transpupillary Thermotherapy (TTT).

After treatment, periodic re-examination is necessary to monitor the response to treatment and detect any changes in the status of the retinopathy, especially any change that would require additional treatment. I understand that it is the patient’s responsibility to maintain follow up appointments necessary after laser treatment. I acknowledge that the nature and the purpose of this procedure, the risks involved, alternatives and the possible complications have been explained to me and that all my questions, if any, have been answered to my satisfaction. I am aware that the practice of medicine & surgery is not an exact science, and I acknowledge that no guarantee can be made as to the results that may be obtained. All this has been explained to me in the language I understand.

I have read, or had read to me, the above information, and I consent to treatment, recognizing the potential risks that are involved.

Signature / Thumb Impression of Patient/ Parent / Guardian: ...........................................................................................................................................
Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ..............................
Name: ..............................
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Tel: ..............................

Witness 2
Signature: ..............................
Name: ..............................
Address: ..............................
Tel: ..............................

Intravitreal Injection for Endophthalmitis

Jatin Ashar, Subrata Mandal

Name of Patient ..............................  Age/Sex  .......  Patient ID  ......................  Date  ......................

Son / Daughter .............................. of ..............................
I have been explained in the language I best understand that drugs would be injected into the vitreous cavity of my eye after appropriate anesthesia to treat and limit the infection in my eye. I have been explained I may or may not regain vision after the procedure and may need a repeat injection or surgery in future. Possible complications of the procedure include retinal detachment, glaucoma, hypotony, cataract, and bleeding. I may also experience side effects such as eye pain, subconjunctival hemorrhage, swelling of the cornea and inflammation of the eye. As with any medication, there is a risk of causing allergic reactions in a small number of patients. Symptoms of allergic reactions include rash, hives, itching and shortness of breath.

I also understand that my eye condition may not get better or may worsen. Any or all the complications explained to me may cause a further deterioration in vision or have a possibility of blindness. Additional procedure may be required for management of the complications.

The nature of my eye condition has been explained to me and the proposed treatment has been described. The risks, benefits, alternatives, and limitations of treatment have been discussed with me. All my questions have been answered.

I here by authorize the doctor to administer intravitreal antibiotics in my R/L eye.

This consent is valid until I revoke it or my condition changes to a point that the risks and benefits of the injection are significantly different from this date.

---

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date
Electrophysiological Tests

Courtesy: Shroff Eye Centre, New Delhi

Name of Patient ................................... ...........  Age/Sex ........ Patient ID ...................... Date .................

Son / Daughter of .............................................................................................................................................................

Address ........................................... ................................................................ Tel. ..............................................................

Electro-Retinogram (ERG)
This investigation procedure comprises of electrodes, which are put on the cornea and on the skin with which a signal is generated from the retina in response to a flash of light. This tells us the gross retinal function. The test takes about 45 minutes to 1 hour and includes 30 minutes of dark adaptation (sitting in a dark room) which can be a little tiring. Very rarely the contact lens electrodes can cause corneal discomfort or abrasion which can be managed by proper medication. For this test, the pupils need to be dilated after which you may not be able to drive or do near work for atleast 3-4 hours. Sometimes, in cases of very small children or uncooperative patients the test needs to be carried out under anesthesia.

Visual Evoked Potential (VEP)
This investigation procedure comprises of electrodes, which are put on the skin with which a signal is generated from visual pathway in response to a flash of light. This tells us the gross visual pathway function. The test takes about 30-45 minutes to perform. For this test, the pupils need not be dilated. Sometimes, in cases of very small children or uncooperative patients, the test needs to be carried out under anesthesia.

Electro - Oculogram (EOG)
This investigation procedure comprises of electrodes which are put on the skin, with which a signal is generated from the retina in response to successive movements of the eye in opposite directions. This tells us the gross retinal function. The test takes about 30-45 minutes to perform. The pupils need not be dilated for this test.

Informed Consent
The information on ERG/EOG/VEP has been read by me / out to me and having understood the content, I give my consent to the performance of this test on me.
Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ........................................................................................................................................................................................................................................... Relationship
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ............................................................
Name: ....................................................................
Address: ...........................................................
Tel: .......................................................................

Witness 2
Signature: ............................................................
Name: ....................................................................
Address: ...........................................................
Tel: .......................................................................
I have been informed in my own language that my right/ left eye may be harboring a tumor/ disease which if not removed may result in loss of vision in the same eye and may lead to spread of the disease to other parts of the body and cause risk to my life.

It has been explained to me that the exact confirmation of diagnosis can be obtained only after microscopic examination after removal of the eye.

The option of removing a piece of tissue through surgery or with the help of a needle for the purpose of diagnosis and its risks involved have been explained and given to me.

I understand that the entire eye along with its coverings and part of the nerve attached to it will be removed and replaced by an artificial prosthesis. I also understand that I will have to wear prosthetic eye for cosmetic purpose after the surgery.

I understand that in spite of the best efforts by the operating surgeons, there may be incomplete removal which may require additional surgery or treatment.

I hereby authorize …………………and those he/ the institute may designate as staff, associates or assistants to perform surgery for removal of my right/left eye.

It has been explained to me that during the course of treatment, unforeseen conditions may be revealed or encountered which may necessitate surgical and emergency procedures in addition to or different from those contemplated at the time of initial diagnosis. I, therefore, further request and authorize the above designated staff to perform such additional surgical or other procedures as they deem necessary or desirable.

I consent to the use of anesthesia and to use of anesthetics as may be deemed necessary or desirable.

I further consent to the administration of such drugs, infusions, plasma or blood transfusion or any other treatment or procedures deemed necessary.
I consent to the observing, photographing or televising of the procedure to be performed for medical, scientific or educational purpose provided my identity is not revealed by the pictures or by descriptive text accompanying them.

I have been given the opportunity to ask all/any questions and I have also been given the option to ask for any second opinion.

I am fully aware that the surgery is being performed in good faith and that no guarantee or assurance has been given as to the result that may be obtained.

Any tissues or parts surgically removed may be disposed off by the institution in accordance with customary practice.

Signature / Thumb Impression of Patient/ Parent / Guardian: .................................................................................................................................

Name: ......................................................................................................................................................................................... Relationship

......................................................... Date ..........................................

Address:

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Phone (Off) ........................................................................ (Res) ........................................................................... (Mob)

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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: .........................................................

Name: .........................................................

Address: .........................................................

Tel: .................................................................

**Witness 2**

Signature: .........................................................

Name: .........................................................

Address: .........................................................

Tel: .................................................................
Evisceration

Noornika Khuraijam

Name of Patient ................................. Age/Sex .......... Patient ID .......................... Date
........................................................................

Son / Daughter of ........................................................................................................................

Address .......................................................... Tel.
........................................................................

I have been informed in my mother tongue that my right/ left eye may be harboring a disease which if not
removed may result in loss of vision in the same eye and may lead to spread of the disease to other parts of the
body and cause risk to my life and a painful blind eye.

I understand that the total contents of the eyeball will be removed and an artificial prosthesis may have to be
implanted to maintain the shape of the eye. I also understand that I will have to wear prosthetic eye for
cosmetic purpose after surgery.

I understand that in spite of the best efforts by the operating surgeons, there may be incomplete removal which
may require additional surgery or treatment. I also understand that the other eye may be affected after surgery,
which may require additional treatment.

I hereby authorize ............................................. and those he/ the institute may designate as staff, associates or
assistants to perform surgery for removal of my right/left eye.

It has been explained to me that during the course of treatment, unforeseen conditions may be revealed or
encountered which may necessitate surgical and emergency procedures in addition to or different from those
contemplated at the time of initial diagnosis. I, therefore, further request and authorize the above designated
staff to perform such additional surgical or other procedures as they deem necessary or desirable.

I consent to the use of anesthesia and to use of anesthetics as may be deemed necessary or desirable.

I further consent to the administration of such drugs, infusions, plasma or blood transfusion or any other
treatment or procedures deemed necessary.

I consent to the observing, photographing or televising of the procedure to be performed for medical, scientific
or educational purpose provided my identity is not revealed by the pictures or by descriptive text
accompanying them.

I have been given the opportunity to ask all/any questions and I have also been given the option to ask for any
second opinion.

I am fully aware that the surgery is being performed in good faith and that no guarantee or assurance has been
given as to the result that may be obtained.

Any tissues or parts surgically removed may be disposed off by the institution in accordance with customary
practice.
Signature / Thumb Impression of Patient/ Parent / Guardian: .................................................................

Name: ............................................................................................................................ Relationship
........................................................................ Date  ....................

Address: ................................................................................................................................................
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Phone (Off) ............................................................... (Res) ........................................... (Mob)
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ............................................
Name: ............................................
Address: ............................................
Tel: ............................................

Witness 2
Signature: ............................................
Name: ............................................
Address: ............................................
Tel: ............................................

Orbitotomy

Rachna Meel

Name of Patient ............................................. Age/Sex ........ Patient ID ........ Date
........................................................................
I have been explained in my mother tongue that a mass has grown adjacent to my left/ right eye. The growth is causing the following:

- Displacement and/ protrusion of the eye ball  Yes/No
- Decrease vision (Which is due to globe distortion and/or compression of the optic nerve)  Yes/No
- Restriction of the movements of the eyeball  Yes/No
- Abnormal deviation of the eyeball  Yes/No
- Drooping of the eyelid  Yes/No
- Altered sensations in the area surrounding the eye (forehead/ nose/ cheek)  Yes/No
- Incomplete closure of the eye  Yes/No

I understand that I need to undergo orbitotomy in order to remove this mass. It is a surgical procedure that involves entering and/or opening up the orbit that is the bony compartment within which the eye is placed. The mass that is removed will then be examined by the pathologist. The histopathological diagnosis will guide further treatment that may involve no further management/ local radiotherapy/ chemotherapy.

I fully understand that it may not be possible to remove the mass completely. The vision, eyeball and eyelid movements, deviation of the eyeball and the sensations around the eye may not recover completely and may even deteriorate due to surgical manipulation.

The surgery has a risk of post operative bleeding and infection in the orbit that may need further treatment in the form of medication or surgery. I also understand the risks of general anesthesia under which this surgery will be done.

Having clearly understood all that is stated above I hereby authorize the doctors to carry out orbitotomy on the right /left side.
**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: .............................................................................................

Name: ...................................................................................................

Address: ..............................................................................................

Tel: ......................................................................................................

**Witness 2**

Signature: .............................................................................................

Name: ...................................................................................................

Address: ..............................................................................................

Tel: ......................................................................................................

**Entropion**

*Prashant Yadav*

Name of Patient .......................................................................... Age/Sex ....... Patient ID ......................... Date

Son / Daughter of

.............................................................................................................................

Address .................................................................................................

....................................................................................................................

I have been explained in my own language the risks and complications of surgery. I have also been fully explained the surgery is being done to correct my lid deformity and there will be no improvement in my vision.

The complications which may occur are enumerated below:

- Infection and gape of the surgical wound
- Suture erosion, infection and granuloma formation
• Lid edema and scar of the incision
• Risks of corneal irritation, injury and ulceration
• Hemorrhage and haematoma formation
• Excessive watering / dry eye,
• Damage to the lid margin
• Loss of eyelashes
• Ptosis and lid retraction.

• A skin graft may be required to correct the deformity. I have been explained that:
  a. The skin graft site maybe post auricular or the anterior forearm
  b. Graft rejection, infection, contracture or fibrosis may occur
  c. It has been explained to me that regular aseptic cleaning of the graft has to be done. It also has been explained to me that the donor site in case of a skin graft may gape or get infected and regular aseptic cleaning of the donor site is required.
  d. A tarsorrhaphy may have to be in place for 3-6 months to prevent contracture of the graft.

• Chances of under correction overcorrection and resurgery have been fully explained.

Signature / Thumb Impression of Patient/ Parent / Guardian:
Name:  ............................................ ............................................................................... Relationship
Date ............................
Address:

Phone (Off) ............................................................... (Res) ........................................... (Mob)

Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ............................................................... Name:  ...........................................................
Name: ...........................................................
Address: ...........................................................
Tel: ...............................................................

Witness 2
Signature: ............................................................... Name:  ...........................................................
Name: ...........................................................
Address: ...........................................................
Tel: ...............................................................
Ectropion

Prashant Yadav

Name of Patient ................................... Age/Sex ........ Patient ID ......................... Date
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Son / Daughter of ..................................................................................................................................................
..........................................................................................................................................................

Address ........................................... ........................................................................................................
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Tel. ..........................................................................................................................................................

I have been explained in my own language the risks and complications of surgery. I have also been fully explained the surgery is being done to correct my lid deformity and there will be no improvement in my vision.

The complications which may occur are enumerated below:

- Infection and gape of the surgical wound
- Suture erosion, infection and granuloma formation
- Lid edema and scar of the incision
- Risks of corneal irritation, injury and ulceration
- Hemorrhage and haematoma formation
- Excessive watering / dry eye
- Damage to the lid margin
- Loss of eyelashes
- Ptosis and lid retraction
- A mucous membrane graft/ nasal septal/ aural cartilage maybe required to correct the deformity. Graft rejection, infection, contracture and/or fibrosis may occur. Regular aseptic cleaning of the graft site has to be done. It also has been explained to me that the donor site (buccal mucosa) of the mucous membrane graft may get infected and I have been explained the importance of regular oral hygiene
- Chances of undercorrection, overcorrection and resurgery have been fully explained

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ......................................................................................................................................................... Relationship
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Date ....................

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Phone (Off) ........................................... (Res) ............................................................ (Mob)
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature
Ptosis

*Dinesh Shrey*

Name of Patient ..................................  Age/Sex ........  Patient ID ..................  Date ..................

Son / Daughter of ..........................................................................................................................

Address ...........................................  Tel. ..........................................................

I have been explained in the language that I understand, that the surgery is being done for drooping of my Rt/ Lt/ Both eyelids under Local Anaesthesia.

During the course of the surgery, there are chances of:

- Undercorrection / Overcorrection after surgery that may require resurgery
- Lid edema, lid swelling and infection
- Inability to fully close the eye (lagophthalmos)
- Lid lag during down gaze leading to scleral show
- Corneal exposure and keratopathy
- Injury to the surface of the eyeball/ globe
- Misdirection of the eyelashes that may point towards the eyes instead of away from it
- Blurred vision or double vision for one or two days postoperatively
- Watering of the eyes for the first few days after surgery
- Scarring at the incision site

Knowing the above mentioned facts, I give my consent for my Rt/ Lt/ Both eyelids ptosis surgery.

Signature / Thumb Impression of Patient/ Parent / Guardian: ..........................................................
Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ...........................................
Name: ............................................
Address: ............................................
Tel: ............................................

Witness 2
Signature: ............................................
Name: ............................................
Address: ............................................
Tel: ............................................

Syringing and Probing

Name of Patient ...................................

Age/Sex ........ Patient ID ..................

Date

Syringing and Probing

Dinesh Shrey

I have been explained in the language that I understand that I / my son / daughter has a block in the passage which is responsible for drainage of tears from eyes to nose. An attempt will be made to open the passage whereby a fine metal probe will be inserted so as to overcome the blockage. The procedure will be done under General Anaesthesia.
• Syringing and Probing is successful in 95% of cases of nasolacrimal duct blockage that are caused by a simple duct blockage.
• The procedure needs to be repeated sometimes if the blockage is not relieved.
• The tear duct may have a complicated type of obstruction or the tear duct might not have developed completely. These complications may be noticed at the time of surgery during probing. Further surgery may be required consequently.
• Bleeding from the nose can occur for up to three days after surgery.
• Lid swelling can occur due to false passage and extravasation of saline.

Knowing the above mentioned facts, I give my consent for my/ my son/ daughter’s surgery.

Signature / Thumb Impression of Patient/ Parent / Guardian: .......................................................................................................................
Name: ............................................................................................................ Relationship ............................................ Date  ......................
Address: ...........................................................................................................
Phone (Off) ............................................................... (Res) ......................................................... (Mob) ............................................................

Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ............................................................
Name: ........................................................................
Address: ..............................................................
Tel: ........................................................................

Witness 2
Signature: ............................................................
Name: ........................................................................
Address: ..............................................................
Tel: ........................................................................
I have been informed in the language I best understand that I am/ my child is suffering from dry eye syndrome due to inadequate production of tears. Blocking the tear drainage system with artificial punctal plugs may improve my symptoms by retaining more tears in the eye. This is a temporary procedure and may be reversible. I have been explained that alternative treatment options include the frequent use of artificial tears or ointment depending on severity of the condition, topical cyclosporine eyedrops or a permanent closure of the punctum and canaliculus by thermal cautery or ligation.

Risks associated with this procedure include infection, excessive tearing, irritation and foreign body sensation, loss of the plug and rarely, lodging of the plug in the tear drainage pathway (canaliculus) leading to scarring. In such cases, surgery may be necessary to re-establish tear drainage. The plugs may require replacement or removal. I have been fully explained the permanent nature of the disease and that this treatment might give symptomatic relief by retaining the tears to moisten the ocular surface. This procedure will not cure the primary cause of dry eye syndrome. Regular follow up may be required to assess the ocular surface status and modify medications accordingly.

I certify that I have fully understood the implications of the above consent and authorise the doctors to insert punctal plugs in my/ my child’s

RIGHT       lower       upper       LEFT       lower       upper       eyelid(s)

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: .................................................................................................................................................. Relationship
................. Date .........................

Address:
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Phone (Off) ............................................................... (Res) ............................................................... (Mob)
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ......................................................
Name: ..........................................................
Address: ......................................................
Tel: ............................................................

Witness 2
Signature: ......................................................
Name: ..........................................................
Address: ......................................................
Tel: ............................................................

Dacryocystorhinostomy (DCR)

Rachna Meel

Name of Patient ..................................... Age/Sex ....... Patient ID ......................... Date

Son / Daughter of

Address ........................................................... Tel.

I have been informed in my mother tongue that the natural passage for tear drainage from my eye (right/ left) is blocked. I understand that in order to overcome the problem of tearing in my eye because of the blockade I need to undergo dacryocystorhinostomy. This surgery involves by-passing the normal drainage system by making a direct communication between this passage and the nose. This will be done by making a bony opening in the adjacent wall of the nose, through a skin incision on the nose. A nasal pack would be kept in the nose for 24 hours post-operatively. Syringing of the passage created by the surgery may be required post-operatively.

I have been explained the risks of this surgery involving: failure ( approx 10%), excessive bleeding during the surgery or postoperatively, infection at the site of surgery and a potential risk of loss of vision due to any of the above reasons. I also understand the risks of local anesthesia under which this surgery will be performed.

Having completely understood the implications of the consent I hereby authorize the doctors to perform dacryocystorhinostomy on my left /right side.
Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: .............................................................................................................................................................. Relationship
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Phone (Off) ............................................................... (Res) ............................................................... (Mob)
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1........................................................................................................................................ Witness 2
Signature: .................................................................................................. Signature: ..........................................
Name: ........................................................................................................ Name: ..................................................
Address: .................................................................................................. Address: ..................................................
Tel: ........................................................................................................ Tel: ........................................................................

Contracted Socket

Prashant Yadav

Name of Patient ................................................. Age/Sex ....... Patient ID .................. Date
........................................................................
Son ............................................................ Daughter of
........................................................................................................................................................................
Address ................................................................................................................ Tel.
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I have been explained in my own language the risks and complications of surgery which is being performed to relieve my orbital socket contracture. These are enumerated below:
• The surgery is being done to correct my contracted socket and there will be no gain in my vision.
• Infection and hemorrhage and gape of the surgical wound may occur.
• Suture erosion, infection and granuloma formation may occur.
• I may require a mucous membrane graft/ amniotic membrane graft or dermis fat graft. I have been explained that:
  a. Graft rejection, infection, contracture or fibrosis may occur.
  b. It has been explained to me that regular aseptic cleaning of the graft has to be done and that the donor site in case of a mucous membrane graft is buccal mucosa. I have also been explained the importance of regular oral hygiene.
  c. In case of dermis fat graft, the graft site will be my gluteal region and I been fully explained the importance of donor site hygiene.
• I will require fornix formation sutures which will be removed after 3 weeks
• I will be required to wear a conformer for 2 months
• I will be given an artificial eye after 2 months. There is a risk of inadequate fitting of the artificial eye. There will only be minimal ocular movements.
• There is a high risk of failure of the socket reconstruction and I may require multiple surgeries.

<table>
<thead>
<tr>
<th>Signature / Thumb Impression of Patient/ Parent / Guardian:</th>
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<tbody>
<tr>
<td>Name: ................................................................................ Relationship ................................................. Date ..........................</td>
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<td>Address: ..................................................................................</td>
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<td>Phone (Off) ............................................................... (Res) ................................................... (Mob) ..........................................................</td>
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</tbody>
</table>

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

| Signature: .......................................................... |
| Name: .............................................................. |
| Address: .......................................................... |
| Tel: ............................................................... |

**Witness 2**

| Signature: .......................................................... |
| Name: .............................................................. |
| Address: .......................................................... |
| Tel: ............................................................... |
I have been informed in my mother tongue that I/ my child is suffering from whitening of the cornea (Corneal opacity) /other disease involving the cornea and that a surgery to remove this along with some normal cornea will be done. A donor cadaveric cornea will be used to replace this and will be placed with help of sutures.

I have been fully explained regarding the permanent nature of the opacity/ lesion and that it has to be removed to enhance vision. I have been explained the risk of infection, graft rejection, suture loosening and replacement, no improvement or worsening of Best corrected visual acuity, glaucoma secondary to surgery or to medications, cataract formation and high astigmatism after surgery. There may be a need for repeat surgery which may or may not lead to improvement of vision. I have been explained the need for follow up as frequently as advised by the doctors that may span upto years, with multiple investigations at each visit. I have been explained that using medications properly is required for success of the graft. I have been explained that I will need to urgently come for follow-up to ophthalmic casualty if there is a sudden onset of redness, photophobia, foreign body sensation, pain or detoriation of vision as these may be early signs of graft infection or rejection. I understand that inspite of all efforts, there is a possibility that there may be worsening of the visual acuity or the cosmetic appearance of the eye.

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform Penetrating Keratoplasty on my / my child’s right / left eye.
Signature / Thumb Impression of Patient/ Parent / Guardian:

Name: .......................................................................................................................... Relationship

Date

Address:

Phone (Off) ............................................................... (Res) ........................................... (Mob)

Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1

Signature: ........................................

Name: ........................................

Address: ........................................

Tel: ........................................

Witness 2

Signature: ........................................

Name: ........................................

Address: ........................................

Tel: ........................................

Therapeutic Keratoplasty

Anand Agarwal, Shalini Mohan

Name of Patient .......................... Age/Sex  ....... Patient ID  .................. Date

Son / Daughter of


Therapeutic keratoplasty is an ocular surgical procedure which is carried out in patients having infections involving the transparent outer coat of the eye ie cornea. The procedure is usually undertaken in cases with impending corneal perforation or frank perforation or sometimes in cases which are not responding to conventional medical therapy and cases with infection spreading onto deeper layers of the cornea. The procedure is usually carried out under general anesthesia but can be performed under local anesthesia as well depending upon the condition of the patient’s eye and systemic status of the patient.

**Post operative care**

The eye may be red, swollen and painful following the procedure for which pain relieving oral medications and some eyedrops are given to bring about relief. Out patient visits are done on first day post operatively, day three, day seven and then after every two weeks. It is very important for you to realize that the primary motive of the surgical procedure is salvaging of the eye, and prevention of spread of infection into the eye which can be devastating. *Attainment of useful vision is only a secondary objective of the procedure for which additional procedures including a repeat corneal replacement may be required at a later date once the infection gets controlled.*

**Post operative course and complications**

1. Corneal wound healing problems including persistent epithelial defect
2. Secondary glaucoma
3. Graft rejection and opacification of the donor cornea
4. Suture related problems including loose, broken sutures, suture abscess
5. Recurrence of original infection in the graft
6. Endophthalmitis and shrinkage of globe- these are rare

It is very important for the patient to realize that you have to be on certain topical medications in the form of antibiotics, local anti inflammatory agents, lubricants etc. for a prolonged period of time to bring about an optimal graft and visual acuity outcome. *Also, the importance of regular follow up as decided by the treating physician cannot be over emphasized.* Needless to say that you are actively involved in the care of the graft to ensure success.

I have been made aware of the above mentioned facts and I have been counseled about the potential benefits and possible side effects of the procedure and by thoroughly going through all of the above, I give my full informed consent for the above procedure.

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Signature / Thumb Impression of Patient/ Parent / Guardian: ........................................................................................................................................................................

Name: ............................................................................................................ Relationship

........................................ Date ........................................

Address: ........................................................................................................................................................................................................

Phone (Off) ............................................................... (Res) ........................................... (Mob)
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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

**Date**

**Witness 1**
Signature: ......................................................
Name: ..........................................................
Address: ..........................................................
Tel: ..............................................................

**Witness 2**
Signature: ......................................................
Name: ..........................................................
Address: ..........................................................
Tel: ..............................................................

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**Automated Lamellar Therapeutic Keratoplasty (ALTK)**

_Gaurav Prakash_

Name of Patient ........................................... Age/Sex .......... Patient ID ..................... Date

Son / Daughter of........................................................................................................................................

Address ..........................................................
Tel. .................................................................

I have been informed in my mother tongue that I/ my child is suffering from whitening of the cornea (Corneal opacity) / corneal ectasia (keratoconus) / other disease involving anterior part of the cornea (specify ..................................................) and that a surgery to remove upto anterior, middle and deep part of the cornea (epithelium, basement membrane & upto mid stroma) will be done. A part of a donor cadaveric cornea will be used to replace this and will be placed with the help of sutures.

I have been fully explained regarding the permanent nature of the opacity/ lesion and that it has to be removed to enhance vision. I have been explained the risk of perforation of the host eye, leading to the need for a full thickness corneal transplant. There is risk of infection, graft rejection, suture loosening and replacement, increased blood vessels in interface possibly leading to haemorrhage, no improvement or worsening of Best corrected visual acuity, glaucoma secondary to surgery or to medications, cataract formation and high astigmatism after surgery. There may be a need for repeat surgery which may or may not lead to improvement of vision. I have been explained the need for follow up as frequently as advised by the doctors that may span upto years, with multiple investigations at each visit. I have been explained that using medications properly is
required for success of the graft. I have been explained that I will need to urgently come for follow-up to ophthalmic casualty if there is sudden onset of redness, photophobia, foreign body sensation, pain or deterioration of vision as these may be early signs of graft infection or rejection. I understand that despite all efforts, there is a possibility that there may be worsening of the visual acuity or the cosmetic appearance of the eye.

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform Automated Lamellar Therapeutic Keratoplasty on my/ my child’s right / left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ............................................ ............................................................................... Relationship
.................................. Date ..........................

Address:
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Phone (Off) ............................................................... (Res) ........................................... (Mob)
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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: ............................................
Name: ............................................
Address: ............................................
Tel: ............................................

**Witness 2**

Signature: ............................................
Name: ............................................
Address: ............................................
Tel: ............................................

**Deep Anterior Lamellar Keratoplasty (DALK)**

Gaurav Prakash

Name of Patient ............................................  Age/Sex ........ Patient ID ........................ Date
Son / Daughter of
............................................................................................................................................................
..................................................................................................................................................................
Address ............................................................................................................................................................ Tel.
..................................................................................................................................................................

I have been informed in my mother tongue that I/ my child is suffering from whitening of the cornea (Corneal opacity) / corneal ectasia (keratoconus) / other disease involving anterior part of the cornea (specify ...................................................) and that a surgery to remove upto anterior, middle and deep part of the cornea (epithelium, basement membrane & stroma upto or just before Descemets) will be done. A part of a donor cadaveric cornea will be used to replace this and will be placed with the help of sutures.

I have been fully explained regarding the permanent nature of the opacity/ lesion and that it has to be removed to enhance vision. I have been explained the risk of perforation of the host eye, leading to the need for a full thickness corneal transplant. There is risk of infection, graft rejection , suture loosening and replacement , increased blood vessels in interface possibly leading to haemorrhage, no improvement or worsening of Best corrected visual acuity, glaucoma secondary to surgery or to medications, cataract formation and high astigmatism after surgery. There may be a need for repeat surgery which may or may not lead to improvement of vision. I have been explained the need for follow up as frequently as advised by the doctors that may span upto years, with multiple investigations at each visit. I have been explained that using medications properly is required for the success of the graft. I have been explained that I will need to urgently come for follow-up to ophthalmic casualty if there is a sudden onset redness , photophobia, foreign body sensation , pain or deterioration of vision as these may be early signs of graft infection or rejection. I understand that in spite of all efforts, there is a possibility that there may be worsening of the visual acuity or the cosmetic appearance of the eye.

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform Deep Anterior Lamellar Keratoplasty on my / my child’s right / left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian: ..................................................................................................................................................................

Name: ............................................................................................................................................................ Relationship
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Address: ..................................................................................................................................................................
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Phone (Off) ............................................................... (Res) ................................................................. (Mob)
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date
I have been informed in the language I best understand that I am suffering from an ocular condition (specify __________ such as Fuchs’ Corneal Dystrophy, trauma, previous intraocular surgery, failed graft) in which a critical number of endothelial cells (inner layer of the cornea) have been lost because of which the cornea has become swollen and cloudy. The remainder of the corneal layers, the stroma and the outer epithelium, are healthy.

An operation known as Descemet’s Stripping Endothelial Keratoplasty (DSEK/DSAEK) will be carried out in which a thin button of donor tissue containing the endothelial cell layer will be inserted onto the back surface of my eye.

Advantages of DSEK over full thickness corneal transplantation are that it is faster to perform, the wound is smaller, more stable and less likely to break open from inadvertent trauma. Because the technique requires very few sutures, there is negligible postoperative astigmatism which can otherwise delay visual recovery. Since only the thin inner layer of the cornea is replaced, over 90% of the patient’s own cornea remains behind contributing to greater structural integrity and a reduced incidence of rejection.

Risks and complications of DSEK/DSAEK

These include general risks similar to those of a full thickness corneal transplantation such as hemorrhage in the eye, infection, a retinal detachment, rejection of the transplanted tissue, chronic inflammation, double vision, loss of corneal clarity, no improvement in vision or worsening of BCVA, glaucoma secondary to surgery or to medications and cataract formation.

Risks specific to DSEK include displacement of the thin button of endothelium within the first few days or weeks after surgery requiring a repeat surgery to reposition it. If the DSEK operation fails, the operation can
be repeated with another button of donor endothelium. Alternatively, a traditional corneal transplant operation can also be performed. Repeat surgery may or may not lead to improvement of vision.

Other complications from the local anesthesia include perforation of the eyeball, damage to the optic nerve, a droopy eyelid, interference with the circulation of the blood vessels in the retina, respiratory depression, and hypotension.

I have been explained the need for follow up as frequently as advised by the doctors that may span upto years, with multiple investigations at each visit. I have been explained that using medications properly is essential for the success of the graft. I have been explained that I will need to urgently come for follow-up to ophthalmic casualty if there is a sudden onset redness, photophobia, pain or deterioration of vision as these may be early signs of graft infection or rejection.

I understand that there may be other unexpected risks or complications that can occur that are not listed here. I also understand that during the course of the proposed operation, unforeseen conditions may be revealed that require 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.

This consent form has also educated me about the various options available to me.

I certify that I have fully understood the implications of the above consent and authorize the doctors to perform endothelial keratoplasty on my right / left eye.

Signature / Thumb Impression of Patient / Parent / Guardian: ......................................................................................................................................................................

Name: ................................................................................................................. Relationship

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Address: .................................................................................................................................................................................................

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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: .............................................. Name: ..............................................

**Witness 2**

Signature: .............................................. Name: ..............................................
Phototherapeutic Keratectomy (PTK)

Chandrashekhar

Name of Patient ............................................. Age/Sex ....... Patient ID ...................... Date ............................................

Son / Daughter ................................................ of ..........................................................

Address ................................................................. Tel. ......................................................

Patient Consent

In giving my permission for excimer laser surgery, I understand the following:

1. The surgical removal of the superficial layers of my cornea using the excimer laser has been elected by me as an alternative to other forms of corneal surgery.

2. As with all surgery, I understand the results cannot by guaranteed.

3. I understand that my vision may be made worse by this procedure. Complications could include: Loss of sharp vision, increased corneal scarring, increased night glare or corneal infection. Any pre-existing viral infections may reappear with the use of post-operative drops. If the cornea has extensive scars, it is possible that a corneal perforation may occur that could produce other changes such as infections, cataracts or the need for additional surgery. I understand that I must be examined closely to ensure proper healing of the treated eye.

4. I understand Phototherapeutic Keratectomy (PTK) with the excimer laser may increase my need for glasses and may require the use of corrective lenses to achieve my best vision.

5. I understand that although sharper vision and less glare are anticipated, it is possible that glare and clarity may be made worse following this procedure.

6. I understand that for those severe corneal problems, where the surgical option for me is a corneal transplant, excimer laser PTK may not eliminate the need for a corneal transplant.

7. I understand it is impossible to state every possible complication that may occur as a result of this surgical procedure.

8. **I understand that not all the beneficial effects of PTK are currently known.**

9. **I also understand that all the risks and complications are not known.**

10. I acknowledge this disclosure of information has been made to me and that all my questions have been answered to my satisfaction. I have read this form (or it has been read to me) and I fully understand the complications, risks and benefits that can result from PTK Surgery. I realize there are no guarantees with PTK Surgery.

   I still however elect to have PTK laser treatment in my R/L / both eye(s).
Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: .......................................................................................................................................................... Relationship
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Phone (Off) ....................................................... (Res) .................................................. (Mob)
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed
the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1                                                   Witness 2
Signature: .................................................................... Signature: ....................................................
Name: ............................................................................. Name: ....................................................
Address: ........................................................................ Address: ....................................................
Tel: .............................................................................. Tel: .......................................................
In giving my permission for PRK, I understand the following:

The long-term risks and effects of PRK surgery are unknown. The goal of PRK with the excimer laser is to reduce dependence upon or need for contact lenses and/or eyeglasses; however, I understand that as with all forms of treatment, the results in my case cannot be guaranteed. For example:

1. I understand that an overcorrection or undercorrection could occur, causing me to become farsighted or nearsighted or increase my astigmatism and that this could be either permanent or treatable. I understand an overcorrection or undercorrection is more likely in people over the age of 40 years and may require the use of glasses for reading or for distance vision some or all of the time.

2. If I currently need reading glasses, I will likely still need reading glasses after this treatment. It is possible that dependence on reading glasses may increase or that reading glasses may be required at an earlier age if I have PRK surgery.

3. Further treatment may be necessary, including a variety of eye drops, the wearing of eyeglasses or contact lenses (hard or soft), or additional PRK or other refractive surgery.

4. My best vision, even with glasses or contacts, may become worse.

5. There may be a difference in spectacle correction between eyes, making the wearing of glasses difficult or impossible. Fitting and wearing contact lenses may be more difficult.

6. I have been informed, and I understand, that certain complications and side effects have been reported in the post-treatment period by patients who have had PRK, including the following:

   A. **Possible short-term effects of PRK surgery:** The following have been reported in the short-term post treatment period and are associated with the normal post-treatment healing process: mild discomfort or pain (first 72 to 96 hours), corneal swelling, double vision, feeling something is in the eye, ghost images, light sensitivity, and tearing.

   B. **Possible long-term complications of PRK surgery:**

      *Haze:* Loss of perfect clarity of the cornea, usually not affecting vision, which usually resolves over time.

      *Starbursting:* After refractive surgery, a certain number of patients experience glare, a “starbursting” or halo effect around lights, or other low-light vision problems that may interfere with the ability to drive at night or see well in dim light. Although there are several possible causes for these difficulties, the risk may be increased in patients with large pupils or high degrees of correction. For most patients, this is a temporary condition that diminishes with time or is correctable by wearing glasses at night or taking eye drops. For some patients, however, these visual problems are permanent. I understand that my vision may not seem as sharp at night as during the day and that I may need to wear glasses at night or take eye drops. I understand that it is not possible to predict whether I will experience these night vision or low light problems, and that I may permanently lose the ability to drive at night or function in dim light because of them. I understand that I should not drive unless my vision is adequate. These risks in relation to my particular pupil size and amount of correction have been discussed with me.

      *Loss of Best Vision:* A decrease in my best vision even with glasses or contacts.

      *IOP Elevation:* An increase in the inner eye pressure due to post-treatment medications, which is usually resolved by drug therapy or discontinuation of post-treatment medications.

      *Mild or severe infection:* Mild infection can usually be treated with antibiotics and usually does not lead to permanent visual loss. Severe infection, even if successfully treated with antibiotics,
could lead to permanent scarring and loss of vision that may require corrective laser surgery or, if very severe, corneal transplantation.

**Keratoconus:** Some patients develop keratoconus, a degenerative corneal disease affecting vision that occurs in approximately 1/2000 in the general population. While there are several tests that suggest which patients might be at risk, this condition can develop in patients who have normal preoperative topography (a map of the cornea obtained before surgery) and pachymetry (corneal thickness measurement). Since keratoconus may occur on its own, there is no absolute test that will ensure a patient will not develop keratoconus following laser vision correction. Severe keratoconus may need to be treated with a corneal transplant while mild keratoconus can be corrected by glasses or contact lenses.

**C. Infrequent complications.** The following complications have been reported infrequently by those who have had PRK surgery: itching, dryness of the eye, or foreign body feeling in the eye; double or ghost images; patient discomfort; inflammation of the cornea or iris; persistent corneal surface defect; persistent corneal scarring severe enough to affect vision; ulceration/infection; irregular astigmatism (warped corneal surface which causes distorted images); cataract; drooping of the eyelid; loss of bandage contact lens with increased pain (usually corrected by replacing with another contact lens); and a slight increase of possible infection due to use of a bandage contact lens in the immediate post-operative period.

I understand there is a remote chance of partial or complete loss of vision in the eye that has had PRK surgery.

I understand that it is not possible to state every complication that may occur as a result of PRK surgery. I also understand that complications or a poor outcome may manifest weeks, months, or even years after PRK surgery.

I understand this is an elective procedure and that PRK surgery is not reversible.

**For women only:** I am not pregnant or nursing. I understand that pregnancy could adversely affect my treatment result.

I have spoken with my physician, who has explained PRK, its risks and alternatives, and answered my questions about PRK surgery. I therefore consent to having PRK surgery on:

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ........................................................................................................... Relationship
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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.
LASIK

Prakashchand Agarwal, Reena Sharma

Name of Patient ........................................... Age/Sex ........... Patient ID ...................... Date

Son / Daughter of

Tel. 

LASIK reshapes the cornea, it involves raising a thin flap of corneal tissue using a blade/ femtosecond laser and remodelling of corneal shape using excimer laser.

During the procedure the patient is required to fix his / her gaze at the blinking light, to ensure proper centration. Clicking sound is heard and a smell similar to that of charring of hair is perceived.

Expected Benefits
I understand the purpose of LASIK is to reduce short sightedness, long sightedness and/or astigmatism to provide me much better unaided vision that I presently have without spectacles or/ and contact lenses. However I understand that an excellent unaided vision may not be guaranteed

Alternative Treatments
I understand that continuous use of spectacles and/or contact lenses can provide excellent vision and LASIK is an alternative to decrease the dependence on spectacles and/or contact lenses.

Possible Side Effects, Risks and Complications
Undercorrection or Over Correction
I understand that calculations used in this surgery are based on previous experience on large number of patients and they use average values. Thus depending on the individual variations in response to the procedure, there might be some undercorrection or over correction. As a result, I may require some spectacles to achieve best possible vision for distance and /or near. If treatment may be required, a period of 6 months must elapse between it and the original surgery.

Presbyopia
I understand that as I get older (45 yrs or older), there is a likelihood of requiring spectacles for reading which is based on natural age related changes in the eye on which there is no direct bearing of the LASIK procedure.

Decrease of Best Corrected Vision
I understand that post-LASIK, best spectacle correction may not be as good as before the procedure.

Glare, Starbursts and Double Vision
These may occur, more so in the first 24 hours. In most cases, they disappear in 1-4 weeks.

Rare Complications
Infection, inflammation, corneal oedema, loss or damage to the corneal flap.

Long Term Changes
There may be alteration in power requiring spectacles or contact lenses.

Technical Failure
It may lead to abandoning the procedure and performing a repeat procedure at a later date.

I certify that I have fully understood the implications of the above consent and authorize the doctors to perform the procedure on my R/L Eye. I have had all the questions answered to my satisfaction.

Signature / Thumb Impression of Patient : .................................................. .................................................................
Name: ................................................................................................................................. Relationship ..................
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Address: ........................................................................................................................................................................
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Phone (Off) .................................................. (Res) .................................................. (Mob) ..............................

Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature
Astigmatic Keratotomy (AK)

Asim K. Kandar

Name of Patient ................................... ...........  Age/Sex .......... Patient ID ...................... Date ............................
Son / Daughter of .............................................................................................................................................................
Address ........................................... ................................................................ Tel. ................................................................

Introduction

Astigmatic keratotomy (AK) is a surgical procedure which consists of making fine microscopic arcuate (curved) incisions, either singly or as a pair, at optical zones of either 6 or 7 mm, or relaxing incisions at the limbus, which is the junction of the clear part of the eye (cornea) with the white (sclera) of the eye. These cuts are made for the purpose of flattening the steepest part of the cornea in an attempt to obtain a more spherical cornea. AK permanently changes the shape of the cornea. Although the goal of AK is to improve vision to the point of not wearing glasses, this result is not guaranteed.

AK is an elective procedure: There is no emergency condition or other reason that requires or demands that you have it performed. You could continue wearing contact lenses or glasses and have adequate visual acuity. This procedure, like all surgery, presents some risks, many of which are listed below. You should also understand that there might be other risks not known to your doctor that may become known later. Despite the best of care, complications and side effects may occur; should this happen in your case, the result might be affected even to the extent of making your vision worse.

Alternatives to AK

If you decide not to have AK, there are other methods of correcting your astigmatism. These alternatives include, among others, eyeglasses, contact lenses, and other refractive surgical procedures such as PRK or LASIK.
Patient Consent

I give my consent to my ophthalmologist to perform AK, and I declare that I have received no guarantee as to the success of my particular case. I understand that the following risks are associated with the procedure:

Potential Risks and Complications

1. I understand that there is a possibility that my vision may not improve with this surgery or that the desired results of surgery may not be obtained. It is possible that I may require additional surgery at a later date or that I could still need glasses after surgery. It is possible that I may not be able to wear contact lenses after having this surgery.

2. As a result of the surgery, it is possible that I could lose vision or best-corrected vision. This could happen as a result of infection that could not be controlled with antibiotics or other means, which could even cause loss of my eye.

3. Irregular healing of incisions may cause the corneal surface to be distorted. In that case, it may be necessary for me to wear a contact lens to affect useful vision, and there is a possibility that this may not restore useful vision.

4. I understand that I may experience incapacitating light sensitivity from sunlight or other bright light sources for a varying length of time, or possibly permanently.

5. I understand that I may experience incapacitating glare or halos from oncoming headlights or other bright light sources, particularly in the evening or at nighttime, for a varying length of time or possibly permanently. I am aware that this may interfere with driving for an indefinite period both during day and night, and I understand that I am not to drive until I am certain that my vision is adequate both during day and night.

6. I understand that fluctuations or variation in vision may occur during the day during the initial stabilization period (up to three months or longer).

7. As occurs in all surgical procedures, scarring is the result of making incisions in living tissue. This particular surgery is no exception.

8. My eye will be more susceptible to a blow to the eye during the healing phase and possibly somewhat after healing as the microscopic scar tissue may not be as strong as the normal tissue. Protective eyewear is recommended for all contact and racquet sports where a direct blow to the eye could cause permanent injury to the eye.

9. Additional reported complications include corneal perforation, which could possibly require sutures; incisional inclusions, corneal vascularization, corneal ulcer formation, endothelial cell loss, epithelial healing defects, and very rarely, endophthalmitis (internal infection of the eye, which could lead to permanent loss of vision).

10. I understand that, as with all types of surgery, there is a possibility of complications due to anesthesia, drug reactions or other factors that may involve other parts of my body. I understand that, since it is impossible to state every complication that may occur as a result of any surgery, the list of complications in this form may not be complete.

Patient’s Statement of Acceptance and Understanding

The details of the procedure known as AK have been presented to me in detail in this document and explained to me by my ophthalmologist. My ophthalmologist has answered all my questions to my satisfaction. I have read this informed consent form (or it has been read to me), and I fully understand it and the possible risks, complications, and benefits that can result from surgery. I therefore consent to AK surgery.

I wish to have AK performed on my R/L/Both eye(s).
Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ................................................................................................................................. Relationship
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Address:
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Phone (Off) ............................................................... (Res) ....................................................... (Mob)
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ..........................................................
Name: ..........................................................
Address: ....................................................... Tel: ..........................................................

Witness 2
Signature: ..........................................................
Name: ..........................................................
Address: ....................................................... Tel: ..........................................................

Intacs
Rashim Mannan, J. S. Titiyal

Name of Patient ............................................. Age/Sex .......... Patient ID ....................... Date
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Son / Daughter of
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Address .................................................................................................................................... Tel.
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Nature of the Intacs Procedure

Intacs® is a non-laser procedure with FDA approval for use in patients with myopia and astigmatism. Intacs are intrastromal corneal ring segments in the shape of a semi-circle which an ophthalmologist inserts into the non-seeing periphery of the cornea through a tiny incision. These segments flatten the central cornea without removing tissue to better focus light. The segments are made of the same material that’s been implanted in human eyes after cataract surgery, called PMMA (polymethylmethacrylate). The procedure is performed under local anesthesia, peri-bulbar block or topical (eye drops) anesthesia. During the procedure, if performed under topical anesthesia, patient has to fix his or her gaze on the bright light of the operating microscope or as instructed by the operating ophthalmologist.

Expected benefits: Intacs® have the advantage of removability or exchangeability for different sized segments, and maintaining a more natural corneal shape. Intacs cannot be felt by the patient, require no maintenance, and are probably less visible than a contact lens to the naked eye. Patients who elect to have Intacs® are not “locked in” to the procedure forever, as are patients who undergo other refractive procedures such as LASIK or PRK.

Alternative treatments: I understand that continuous use of spectacles and/or contact lenses can provide good vision and Intacs® is an alternative to decrease the dependence on glasses and/or contact lenses.

Possible Side Effects, Risks and Complications

1. OVER/UNDER-CORRECTION: I understand that calculations used in this surgery are based on previous experience on large number of patients and these use average values. I understand that Intacs® do not provide a full correction or a full reversal back to eye’s normal refractive state. Rather, the goal is to reduce myopia and astigmatism and/or to alter the shape of the cornea so that contact lenses can have a better fit. Thus depending on individual variations in response to the procedure, there may be some under-correction or over-correction.

2. VISUAL ACUITY FLUCTUATION: I may have blurred vision or fluctuating vision following the procedure, this is due to modulation in the corneal tissue in response to Intacs® in the corneal stroma.

3. LIGHT SENSITIVITY: I may experience glare or halos form light sources, more so during night time. These tend to disappear with time but glare may persist for a long time particularly at night.

4. INDUCED ASTIGMATISM: I understand that I may experience a temporary blurring or distortion of vision for several days after the procedure. This type of visual distortion is normal during the healing process and, in most cases, it decreases over time. However, in rare instances, it may be permanent.

5. PRESBYOPIA AND OTHER OCULAR CONDITIONS: I understand that Intacs® will NOT prevent the development of naturally occurring eye problems such as glaucoma, cataracts, retinal degeneration, or detachment. Further Intacs® do not correct the condition known as presbyopia (or aging of the eye), which may require reading glasses for close work at about age 40.

6. OTHER COMPLICATIONS: Like any other surgical procedure of the eye, insertion of Intacs® can lead to trauma to corneal tissue leading to corneal edema, perforation, infection, which if severe could result in the loss of the eye or, rarely, a cataract. I understand that stromal thinning may occur due to shallow placement, which would require removal of the Intacs®. Further I have been made fully aware that if there are complications or problems during the surgery, the surgeon may not be able to insert Intacs®, and the surgery may have to be cancelled.

There are other risks associated with any surgery. Since it is impossible to state every risk or complication that may occur as a result of any surgery, the possible risks and complications listed in this informed consent may be incomplete. There may be risks or complications associated with this surgery that are unknown because this is a relatively new procedure.

I hereby give permission to release/publish medical data and/or video/audio record/photograph the current procedure and the procedures performed in subsequent/ follow up visits for the advancement of medical knowledge.
In signing this consent form for insertion of Intacs® I am stating that I have read this consent form (or it has been read to me) and I fully understand the nature and the purpose of and the possible side effects, risks and complications of this procedure. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction.

I give permission to perform Intacs® insertion on my R/L/Both eye(s).

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ............................................................................................................................ Relationship
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**Declaration by Doctor**
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**
Signature: ...........................................
Name: ..................................................
Address: .........................................
Tel: ...................................................

**Witness 2**
Signature: ...........................................
Name: ..................................................
Address: .........................................
Tel: ...................................................
Phakic IOL

Rashim Mannan, J. S. Titiyal

Name of Patient ..............................................  Age/Sex ........ Patient ID ..................... Date .....................

Son ........................................................................ Daugther of ........................................

Address .............................................................. Tel. ..........................................

Nature Of The Phakic IOL Procedure

Surgical implantation of a phakic intraocular lens is one of a number of alternatives for correcting nearsightedness. In phakic implant surgery, an artificial lens (such as the ICL or Verisyse phakic intraocular lens) is surgically placed inside your eye. The lens is made from material similar to the type used for intraocular lenses currently being implanted in the eye to correct vision after cataract surgery. The difference between phakic implant surgery and other intraocular lens implants is that your natural lens is not removed during phakic implant surgery. The phakic lens is inserted in addition to your natural lens. The procedure is performed under local anesthesia, peribulbar block.

The surgeon will make two small holes in the colored portion of your eye (the iris) to help ensure that intraocular fluid does not build up behind the phakic lens; this procedure is called an iridotomy. It will take place either at the time of surgery by using an instrument (a surgical iridotomy) or within two weeks before the placement of the phakic implant by using a laser (YAG-laser iridotomy).

Indications & Expected Benefits

If you have myopia, hyperopia or astigmatism, phakic implant surgery may improve your natural vision without the use of glasses or contacts. Further they have the advantage of removability and maintaining a more natural corneal shape. Phakic IOL cannot be felt by the patient, require no maintenance, and are less visible than a contact lens to the naked eye. Patients who elect to have Phakic IOL implants are not “locked in” to the procedure forever, as are patients who undergo other refractive procedures such as LASIK or PRK.

Alternative Treatment

I understand that continuous use of spectacles and / or contact lenses can provide good vision and Phakic IOL is an alternative to decrease the dependence on glasses and / or contact lenses.

Possible Side Effects, Risks And Complications

Vision Threatening Complications:

ANAESTHETIC COMPLICATIONS: In most cases, the surgery will be accomplished with use of an injection around the eye for anesthesia. Very rare complications from injections include damage to the eye muscles, perforation of the eye, and damage to the retina or optic nerve leading to loss of vision.

INFECTION: I understand that mild or severe infection is possible. Mild infection can usually be treated with antibiotics and usually does not lead to permanent visual loss. Severe infection, even if treated with antibiotics, could lead to permanent scarring and loss of vision.

IRIS ATROPHY: I understand that I could experience damage to the iris (the colored portion of the eye) leading to iris atrophy or develop a rise in the pressure in my eye (secondary glaucoma). I may require another iridotomy if this occurs or eye drops to control the pressure.
RETINAL DETACHMENT: I understand that I could develop a retinal detachment, a separation of the retina from its adhesion at the back of the eye, which usually results from a tear in the retina and could lead to vision loss. Patients with moderate to high levels of nearsightedness have a higher risk of retinal detachment when compared to the general population. This risk level may be increased with implantation of the phakic IOL.

CATARACT: I understand that I may develop a cataract, or a clouding of the eye’s natural lens, which impairs normal vision, and may require removal of the lens, the phakic implant, and insertion of an artificial lens.

CORNEAL INVOLVEMENT: I understand that I may develop corneal swelling (edema) and/or ongoing loss of cells lining the inner surface of my cornea (endothelial cells). These cells play a role in keeping the cornea healthy and clear. Corneal edema and loss of endothelial cells may result in a hazy and opaque appearance of the cornea, which could reduce vision and may require a corneal transplant.

GLAUCOMA: I understand that I may develop glaucoma, which is an increase in the pressure of the eye caused by slowed fluid drainage. Glaucoma can lead to vision loss, and may require treatment with long-term medications or surgery.

I understand that other complications could threaten my vision, including, but not limited to, iritis or inflammation of the iris (immediate and persistent), uveitis, bleeding, swelling in the retina (macular edema), and other visual complications. Though rare, certain complications may result in total loss of vision or even loss of the eye. Complications may develop days, weeks, months, or even years later.

Non-vision-threatening Side Effects

GLARE OR HALOS: I understand that there may be increased sensitivity to light or night glare. I also understand that at night there may be a “starbursting” or halo effect around lights. The risk of this side effect may be related to the size of my pupil, and larger pupils may put me at increased risk.

UNDER/OVER CORRECTION: I understand that an over-correction or under-correction could occur, causing me to become farsighted, remain nearsighted, or increase my astigmatism and that this could be either permanent or treatable with either glasses, contact lenses, or additional surgery.

REPEAT SURGERY: I understand that the phakic lens may need to be repositioned, removed surgically, or exchanged for another lens implant. The lens may change position (decentration), or I may require a different size or power of lens than that of the implanted lens. Potential complications of additional surgery include all of the complications possible from the original surgery.

PROTECTIVE GLASSES: I understand that, after phakic implant surgery, the eye may be more fragile to trauma from impact. I understand that the treated eye, therefore, is somewhat more vulnerable to all varieties of injuries. I understand it would be advisable for me to wear protective eyewear when engaging in sports or other activities in which the possibility of a ball, projectile, elbow, fist, or other traumatizing object contacting the eye may be high.

PRESBYOPIA: I understand that if I currently need reading glasses, I will still likely need reading glasses after this treatment. It is possible that dependence on reading glasses may increase or that reading glasses may be required at an earlier age if I have this surgery.

I understand that the correction that I can expect to gain from phakic implant surgery may not be perfect. I understand that it is not realistic to expect that this procedure will result in perfect vision, at all times, under all circumstances, for the rest of my life. I understand I may need glasses to refine my vision for some purposes requiring fine detailed vision after some point in my life, and that this might occur soon after surgery or years later.

I understand that, since it is impossible to state every complication that may occur as a result of any surgery, the list of complications in this form may not be complete.
I understand that because I have a phakic lens, it is important for me to be seen at all follow-up visits as felt necessary by my surgeon.

I hereby give permission to release/publish medical data and/or video/audio record/photograph the current procedure and the procedures performed in subsequent/ follow up visits for the advancement if medical knowledge.

In signing this consent form for insertion of Phakic IOL I am stating that I have read this consent form (or it has been read to me) and I fully understand the nature and the purpose of and the possible side effects, risks and complications of this procedure. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction.

I give permission to perform phakic IOL insertion on my R/L/Both eye(s).

Signature / Thumb Impression of Patient/ Parent / Guardian:  
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Name: ................................................................................................................ Relationship ........................................ Date ............................
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ......................................................  Name: ..........................................................
Address: ........................................................ Tel: ..............................................................

Witness 2
Signature: ......................................................  Name: ..........................................................
Address: ........................................................ Tel: ..............................................................
Conductive Keratoplasty

Chandrashekhar

Name of Patient ................................... ...........  Age/Sex ........ Patient ID ....................... Date
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Son / Daughter of 
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Address ........................................... ................................................................ Tel. 
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In giving my permission for Conductive Keratoplasty (CK) I understand the following:

The long-term risks and effects of CK are unknown. I have received no guarantee as to the success of my particular case. I understand that the following risks are associated with the procedure:

1. I understand that the visual acuity I initially gain from CK could regress, and that my vision may go partially or completely back to the level it was immediately prior to having the procedure

2. I understand that it is possible that damage to my cornea could also be caused by scarring, ulceration, or an eye infection that could not be controlled with antibiotics or other means

3. I understand that I may not get a full correction from my CK procedure and this may require future enhancement procedures or the use of glasses or contact lenses. This procedure may also cause an increase in my astigmatism, which may cause blurred vision

4. I understand that an over-correction could occur, causing me to become nearsighted, and that this nearsightedness could be either permanent or treatable

5. I understand that the correction that I can expect to gain from CK may not be perfect and it is not realistic to expect that this procedure will result in perfect vision, at all times, under all circumstances, for the rest of my life. I understand I may need glasses to refine my vision for some purposes requiring fine detailed vision after some point in my life, and that this might occur soon after surgery or years later

6. I understand that there may be pain, scratchiness, a foreign body sensation, or slight dryness in my eye, particularly during the first 48 hours after surgery

7. I understand that there may be increased sensitivity to light. I understand this condition usually resolves within the first few weeks following treatment, but it may also be permanent

8. I understand that there may be a “balance” problem between my two eyes after CK has been performed on one eye, but not the other. This phenomenon is called anisometropia. I understand this would cause eyestrain and make judging distance or depth perception more difficult. I understand that my first eye may take longer to heal than is usual, prolonging the time I could experience anisometropia

9. I understand I may temporarily experience corneal haze, small round hazy areas where the cornea was heated during the CK treatment. This haze will usually fade over time and may only be visible with a microscope within 3 months following surgery

10. I understand that if I currently need reading glasses, I will still likely need reading glasses after this treatment
11. Even 90% clarity of vision is still slightly blurry. Enhancement surgeries can be performed when vision is stable UNLESS it is unwise or unsafe. An assessment and consultation will be held with the surgeon at which time the benefits and risks of an enhancement surgery will be discussed.

12. I understand that there is a natural tendency of the eyelids to droop with age and that eye surgery may hasten this process.

13. I understand that the follow-up effects of CK are unknown and that CK has not been in use long enough to measure long-term effects (those occurring after 10 years or more) following the procedures, and that unforeseen complications or side effects could occur.

14. I understand that I may be given medication in conjunction with the procedure. I understand that I must not drive for at least one day following the procedure and not until I am certain that my vision is adequate for driving.

15. I understand that, as with all types of surgery, there is a possibility of complications due to anesthesia, drug reactions, or other factors that may involve other parts of my body. I understand that, since it is impossible to state every complication that may occur as a result of any surgery, the list of complications in this form may not be complete.

The details of the procedure known as CK have been presented to me in detail and explained to me by my ophthalmologist. My ophthalmologist has answered all my questions to my satisfaction. I therefore consent to CK surgery my R/L eye.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name:....................................................................................................................... Relationship

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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date
I have been explained in the language that I understand that I have a fold of conjunctiva enroaching upon the cornea in my R/L eye, which is to be surgically removed. The following has been explained to me:

- Corneal opacity would persist after surgery
- Risk of recurrence of fold and need for repeat surgery
- Visual prognosis remains guarded in view of persisting astigmatism, hence vision may / may not improve after removal of the lesion
- A piece of conjunctiva from the same / other eye may be required to prevent recurrence of the fold if an autoconjunctival graft is planned after excision
- If Mitomycin C is applied after excision to decrease the incidence of recurrence, risk of scleral thinning has been explained
- Redness, irritation, watering may persist for a few days after surgery
- In case of autograft, sutures will be applied and may lead to irritation. Risk of infection of the graft has been explained
- Additional laser procedure may be required for removal of corneal opacity after surgery
- Surgery would be done under local infiltration/ anesthetic drops

After knowing all this, I give my free and voluntary consent to undergo pterygium excision i.e. removal of conjunctival fold from my eye.
Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.
I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
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Witness 2
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Address: ............................................
Tel: ............................................

Corneal Scraping

Saurbhi Khurana

Name of Patient ............................................. Age/Sex ....... Patient ID .......................... Date ..........................

Son / Daughter of .............................................

Address ........................................................

Tel. ........................................................

I have been explained in my own language that I am suffering from an ocular infection i.e. a corneal ulcer in my R/L eye. I am to undergo a diagnostic procedure in the form of a corneal scraping for the same. The following has been explained to me:

• After topical anaesthesia, material would be taken from the ulcerated area with the help of a needle and sent for investigations.
The procedure is being done to isolate the organisms responsible for the infection in order to start appropriate treatment for the same.

This is not a therapeutic procedure and will not lead to improvement in symptoms/ healing of the lesion or in visual recovery.

There is a risk of corneal perforation during the procedure for which surgical intervention may be required.

This procedure may/ may not isolate the organism responsible for the infection and accordingly may have to be repeated.

After knowing all this, I give my free and voluntary consent to undergo corneal scraping from my R/L eye.

Signature / Thumb Impression of Patient / Parent / Guardian:
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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ..........................................................
Name: ..........................................................
Address: ....................................................
Tel: ..........................................................

Witness 2
Signature: ..........................................................
Name: ..........................................................
Address: ....................................................
Tel: ..........................................................
Fibrin Glue Adhesive for Corneal Perforation

Kiran G.

Name of Patient ...........................................  Age/Sex ..........  Patient ID .........................  Date
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Son / Daughter of ........................................................................................................................................................................................................
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I have been clearly explained in the language I best understand that in view of my (diagnosis-corneal perforation), application of fibrin glue will be attempted to seal the defect.

I have also been informed of the fact that this procedure is being attempted because the tissue defect in my cornea is less than 2 mm in diameter.

I am fully aware of the risk of failure of the procedure which may necessitate reapplication of the glue or alternate treatment modalities like corneal patch grafting.

I am also aware of the fact that glue may produce inflammation of varying intensities in the eye and that the risk of endophthalmitis is greater with this procedure than a patch graft.

Nevertheless, I wish to have the procedure performed in my R/L eye and I am willing to accept the potential risks that my doctor has discussed with me.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature
Symblepharon Release

Reena Sharma

Name of Patient ................................... Age/Sex .......... Patient ID ...................... Date
Son / Daughter of .................................................................
Address ................................................................. Tel.

I have been informed in my mother tongue that I/ my child is suffering from adhesion of ocular surface and lids (Symblepharon) due to disease involving the conjunctiva and cornea and that a surgery to remove this will be done. An amniotic membrane graft (human placental tissue) or mucous membrane graft may be applied to the ocular surface with the help of sutures. Bandage contact lens will be applied after the surgery.

I have been fully explained regarding the permanent nature of the lesion and that it has to be released to improve the ocular surface. This procedure primarily will not improve vision. I have been explained the risk of inadvertent perforation of the eye during the surgery, infection, inadequate release or reformation of adhesions. There may be a need for repeat surgery which may or may not lead to improvement of vision. I have been explained that proper use of medications is required for success of the treatment. I understand that inspite of all efforts, there is a possibility that there may be no improvement or worsening of the visual acuity or the cosmetic appearance of the eye.

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform symblepharon release with/ without AMT on my/ my child’s right / left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian: ..........................................................................................................................
Amniotic Membrane Transplantation (AMT)

Asim K. Kaudar

Name of Patient ........................................... Age/Sex ........ Patient ID .................... Date
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Son / Daughter of ........................................................................................................
Address ..........................................................................................................................
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Decloration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1

Signature: .................................................................
Name: .........................................................................
Address: ......................................................................
Tel: ...............................................................................

Witness 2

Signature: .................................................................
Name: .........................................................................
Address: ......................................................................
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I have been informed in my mother tongue that I/ my child is suffering from a disease involving the ocular surface (specify ....................................) and that a surgery will be performed in which an amniotic membrane (covering of the foetal sac) will be used to cover the ocular surface. The amniotic membrane will be sutured into place with circumferential interrupted sutures with 10-0 monofilament nylon sutures and the peripheral edge of the membrane will be sutured to the conjunctiva with 8-0 polyglactin interrupted sutures. The excess membrane will be trimmed and a bandage contact lens will be put after surgery.

I have been fully explained regarding the permanent nature of the opacity/ lesion. I have been explained the risk of perforation of the host eye, leading to the need for a full thickness corneal transplant. There is risk of infection, suture loosening and replacement, increased blood vessels in interface possibly leading to haemorrhage, no improvement or worsening of best corrected visual acuity and pain, glaucoma secondary to surgery or to medications after surgery. The membrane may shed off prematurely leading to repeat surgery which may or may not lead to improvement of vision. I have been explained the need for follow up as frequently as advised by the doctors that may span upto years, with multiple investigations at each visit. I have been explained that use of medications properly is required for success of the surgery. There is chance of falling of the bandage contact lens and it may require replacement. I have been explained that I will need to urgently come for follow-up to ophthalmic casualty if there is sudden onset redness, photophobia, pain or deterioration of vision as these may be early signs of amniotic membrane infection. I understand that in spite of all efforts, there is a possibility that there may be worsening of the visual acuity or the cosmetic appearance of the eye.

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform Amniotic Membrane Transplantation on my right / left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian: ..........................................................................................................................................................................................................................................................

Name: ........................................................................................................................ Relationship .................................. Date ............................

Address: ..........................................................................................................................................................................................................................................................................................................................

Phone (Off) ............................................................... (Res) ............................................................... (Mob) ............................................................... ............................................................

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**
Signature: ..............................................
Name: .....................................................
Address: .....................................................

**Witness 2**
Signature: ..............................................
Name: .....................................................
Address: .....................................................
Limbal Stem Cell Transplantation (LSCT)

Asim K. Kaudar, Bhavna Chawla

Name of Patient ................................... ...........  Age/Sex .......... Patient ID ....................... Date 
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Son / Daughter of .............................................................................................................................................................

Address ........................................... ................................................................ Tel. ................................................................

I have been informed in the language I best understand that I/ my child is suffering from an ocular surface 
disease with conjunctivalization of the cornea (specify .........................................) and that a surgery to 
improve the ocular surface will be done along with removal of the superficial part of the cornea depending 
upon depth of involvement. A part (limbal tissue) of a donor cadaveric cornea / from opposite normal eye / 
from live related donor will be used either directly or after expansion in tissue culture media to replace the 
diseased tissue with the help of sutures.

I have been fully explained regarding the permanent nature of the disease and that this treatment is intended to 
improve the ocular surface. I have been explained the risk of perforation of the host eye, leading to full 
thickness corneal transplant. There is a risk of infection, graft rejection, suture loosening and replacement, 
increased blood vessels possibly leading to haemorrhage, no improvement or worsening of best corrected 
visual acuity. The opacity may increase after the surgery. There may be a need for repeat surgery which may or 
may not lead to improvement of vision. I have been explained the need for follow up as frequently as advised 
by the doctors that may span upto years, with multiple investigations at each visit. I have been explained that 
using medications properly is required for success of the graft. I have been explained that I will need to 
urgently come for follow-up to ophthalmic casualty if there is a sudden onset of redness, photophobia, foreign 
body sensation, pain or deterioration of vision as these may be early signs of infection or rejection. I understand 
that inspite of all efforts, there is a possibility that there may be worsening of the visual acuity or the cosmetic 
appearance of the eye.

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform 
Limbal Stem Cell Transplantation on my right / left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian: .............................................................................................................

Name: ................................................................................................................................................................................. Relationship 
................................................................................................................................. Date .............................

Address: ..............................................................................................................................................................................
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: ......................................................
Name: ................................................................
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Witness 2
Signature: ......................................................
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Address: ........................................................
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Osteo-odonto Keratoprosthesis (OOKP)

Noopur Gupta, Radhika Tandon

Name of Patient .............................................. Age/Sex ........ Patient ID ................ Date ....................

Son / Daughter of ........................................................................................................................

Address ................................................................................................................................................
Tel. .......................................................................................................................................................

I have been informed in my mother tongue that I will need a specially designed keratoprosthesis where the artificial cornea is embedded in a biological frame made of the canine tooth to enhance support and long-term stability of the visual aid to treat my blind eye/eyes as this is the last option of restoring vision in my present condition and no other surgical procedure e.g. keratoplasty will be successful as I have severe dry eyes also.

I understand that Keratoprosthesis will replace my opaque, white cornea and act like a telescope, so that the light rays can go in the eye and reach the retina (back of the eye which is the seeing machinery of the eye) and I will be able to see.

I have been fully explained that for osteo-odonto-keratoprosthesis (OOKP), one of my healthy canine tooth/teeth will be harvested for the surgery and a layer of the inner lining of the cheek will also be taken to
cover the surface of the eye. The surgery will be done in two stages which will be two months apart, so it may take a long time to gain vision after the first stage of the surgery.

I have been explained the potential benefits and risks of the procedure and that there is a possibility of no visual gain after surgery. There may be potential complications like extrusion or necrosis of the OOKP lamina, infection in the eye and increased pressure in the eye. There may be need of further surgeries if tissue grows over the OOKP cylinder or a membrane forms behind the cylinder, both of which will need to be removed.

I certify that I have fully understood the implications of the above consent and authorize the doctors to perform OOKP surgery in my right/ left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian: ............................................................................................................................

Name: .......................................................................................................................... Relationship

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Address: ..........................................................................................................................

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Phone (Off) ............................................................... (Res) .................... ........................................... (Mob)

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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1

Signature: ......................................................

Name: ......................................................

Address: ......................................................

Tel: ......................................................

Witness 2

Signature: ......................................................

Name: ......................................................

Address: ......................................................

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Information about Squint

Adults & children of any age with eye deviation may benefit from eye muscle surgery to make both eyes look straight. This will help maximizing the chance of binocular fusion (3-D vision/depth perception) and normalizing the field of vision. Apart from making them look cosmetically better, squint surgery may also allow patients to see more comfortably with a relaxed head position.

Events during surgery

- General anesthesia is given in children & some special squint cases.
- Local anesthesia in the form of injections around the eye is given in adults.
- During surgery, one eye or both eye muscles are either tightened or loosened & the positions of the eye muscles are changed to make eyes look straight.

Risks associated with Squint surgery

While we are unable to list every possible complication, the following are some potential risks.

Major risks

1) Due to anesthesia (both general & local) – includes breathing difficulties, vomiting, sore throat, or even risk of heart attack or death. Local complications of anesthesia injections around the eye can be in the form of perforation of eyeball, destruction of optic nerve, interference with circulation of retina, drooping of eyelid, hypotension & respiratory depression.

2) Need for reoperation – Over- and under-correction after surgery is common. A reoperation may be necessary because a totally predictable response is not possible in every case. Need for reoperation may be high in cases where prior surgery has been performed, when the squint is complicated, in cases of a slipped or lost muscle, excessive hemorrhage, or fat exposure. Reoperation in some cases may be needed in the other (normal) eye also later to fine tune the surgical results.

3) Loss of vision – is quite rare but can be associated with anesthesia or other causes like hemorrhage, retinal detachment (after needle perforation), infection, or change in blood supply to the eye.

Minor risks: include inflammation of the eye (conjunctivitis), reaction to the sutures, pain, temporary double vision, temporary blurry vision, alteration of the eyelid position and scar tissue formation including implantation cysts.

General information
• Discomfort of eyes, redness & swollen eyelids for the first few days after surgery is common.
• If child wears glasses, they will likely continue to wear glasses after the surgery.
• Eyes are not patched after surgery & usually there is no permanent scar.
• Eye drops are given 3 to 6 times a day for up to 1 month after surgery.
• Temporary double vision after surgery is common.
• Absorbable sutures are used & need not be removed after surgery.

Additional comments:
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I have read & understand the consent form including potential risks & benefits of the squint surgery. I have discussed with my treating eye surgeons & am satisfied with the explanation provided & I authorize them to proceed with my/child’s surgery. Occasionally a different, unsuspected condition may arise at the time of surgery requiring immediate attention, and I authorize my surgeon to do what he/she deems necessary.

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Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name:  .......................................................................................... Relationship  .................................... Date  ......................

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Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1

Witness 2
Botox (Botulinum Toxin) Injection

Shailesh G.M, Rohit Saxena

Name of Patient ................................................. Age/Sex ........ Patient ID ......................... Date

Son / Daugther of .................................................................................................................................

Address ..................................................................................................................................................

Tel. .........................................................................................................................................................

I .............................................................................. have discussed my illness with my treating eye surgeon and
I consent to having Botox treatment carried out upon myself for the improvement of
..........................................................................................................................................................

Botox is injected with a small needle into the skin/muscle, with the aim of inhibiting the underlying muscle
contraction, therefore improving my underlying muscle spasms/illness. In squint cases, the injection will
weaken the overacting muscle & help in making the eye look straight. Botox injection also gives additional
information about squint and can be used instead of performing surgery.

I have been informed about the indications, treatment procedure, expected results & possible side effects. I
understand that I may experience swelling, redness, tenderness, flu-like syndrome, temporary muscle aching,
as well as paralysis of a nearby muscle (which can cause droopy eyelids, double vision, droopy mouth, or neck
weakness), slight headache, pain and/or bruising that may occur for several days after my treatment, howeaver
these symptoms will resolve.

Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact
science and that no guarantees can be made concerning the expected results in my case. The injection will take
3-4 days to start acting & will usually last for up to 3 months. Repeated injections may be required as the effect
starts decreasing from 3-months onwards.

I understand that I am required to have a follow-up consultation at 2 weeks, and that I am required to have
photographs taken before, during and after treatment for my medical records.

Contraindications

You should not have Botox if you are pregnant; nursing; allergic to albumin; have an infection, skin condition,
or muscle weakness at the site of the injection; or have Eaton-Lambert syndrome, Lou Gehrig’s disease, or
myasthenia gravis. Botox contains human-derived albumin and carries a theoretical risk of virus transmission.
I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Signature / Thumb Impression of Patient/ Parent / Guardian: .......................................................... ..........................................................

Name: ............................................................................................................................................... Relationship ........................................................................ Date ...........................................

Address: ........................................................................................................................................................................................................

Phone (Off) ............................................................... (Res) ............................................................... (Mob) ............................................................... ..........................................................

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient. I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: ...........................................................
Name: ...........................................................
Address: ...........................................................
Tel: ...............................................................

**Witness 2**

Signature: ...........................................................
Name: ...........................................................
Address: ...........................................................
Tel: .............................................................

**GLAUCOMA**
Indications, Benefits, and Alternatives

I have been informed by my treating doctor that I have been diagnosed with glaucoma and if it is left untreated, it is very likely that I will experience loss of vision which could end up in blindness. Glaucoma means rise in pressure of the eye which can sometimes be treated successfully with medications, or if medications are not effective, laser and other surgical procedures may be of value in controlling the pressure and preventing further vision loss.

My doctor has informed me that an operation called trabeculectomy is necessary to help control the pressure in my eye(s) because prolonged rise of this pressure can damage my optic nerve leading to loss of vision and eventual blindness. When successful, this procedure will lower the pressure in my eye, minimizing the risk of further vision loss from glaucoma. The purpose of the operation is to control the pressure and preserve my vision; any vision lost to glaucoma cannot be restored.

Complications

As with any surgical procedure, there are risks associated with glaucoma drainage surgery. For example, there is always the possibility that the surgery cannot control my eye pressure, for which medications or more procedures may be needed after surgery. Not every possible complication can be covered in this form but the following are examples of risk encountered with glaucoma drainage surgery. These complications can occur days, weeks, months, or years later. They can result in loss of vision or blindness. So frequent follow-up is mandatory after surgery.

After complete healing also, regular eye examination is necessary to monitor eye pressure and to look for other problems.

Complications of the surgery

1. Failure to control eye pressure, with the need for another operation (early or late)
2. Generally vision might decrease for 2 months or so. There may be development of cataract which can reduce vision but it can be treated with cataract surgery
3. There might be too high or too low pressure after glaucoma surgery for which other necessary treatment or operation might be needed.
4. Bleeding in the eye
5. Pronged redness and mild pain resulting in chronic inflammation
6. Irritation or discomfort in the eye that may persist
7. In spite of surgery, vision could become worse from continuing degenerative changes in the eye
8. Infection resulting in pain, redness and decrease in vision which can occur early or much later
9. In rare cases, there could be total loss of vision

Operation will be done under local or general anesthesia which also includes complications of anesthesia.

**Complications of anesthesia injections around the eye**

10. Perforation of eyeball
11. Needle damage to the optic nerve, which could destroy vision
12. Interference with circulation of the retina
13. Possible drooping of eyelid
14. Systemic effects that have the potential for life-threatening complications and death

**Patient Consent**

There may arise unwanted situation during surgery. In that situation I give my full authority to my treating doctor to take any necessary decision. In spite of the risks noted above, I understand that there is more risk to my vision if I do not have the operation than if I do. I have read and understood the consent form, and all my queries have been answered, and I authorize my surgeon to proceed with the operation on my ......................... (indicate “right” or “left” eye).

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**Signature / Thumb Impression of Patient/ Parent / Guardian:**

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Name: ............................................ .......................................................... Relationship

............................... Date  ......................

Address:

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Phone (Off) .................................................. (Res) .................................................. (Mob)

............................................................................................

**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

**Witness 2**
Diode Laser Cyclo-photocoagulation (DLCP)

Anand Agarwal, Shalini Mohan

Name of Patient ...........................................  Age/Sex ...........  Patient ID .........................  Date

Son / Daughter of ........................................................................................................................................................................

Address .................................................................  Tel. .................................................................

DLCP is an ocular surgical procedure which is usually carried out in people with advanced, recalcitrant glaucoma who have uncontrolled high intraocular pressures (IOPs) despite use of medications and repeated glaucoma filtration surgeries and use of glaucoma drainage devices (GDDs). This procedure is effective in bringing down IOPs and relieving ocular pain if the cause of pain is high IOP. The procedure is usually carried out under local peribulbar anesthesia and sometimes more than one sitting needs to be given i.e. the procedure may have to be repeated to bring about clinical success.

**Post operative care**

The eye may be red, swollen and painful following the procedure for which pain relieving oral medications and some drops are given to bring about relief. Outpatient visits are done on first day postoperatively, day seven and then after every two weeks.

The need for repeat procedure is decided by the treating physician after evaluating patient’s symptoms and IOP.

The usual side effects encountered are:

1. Ocular pain
2. Redness
3. Periocular swelling
4. Need for repeat treatments
5. The procedure may be able to bring down the need for IOP lowering medications although some of them may be required to maintain optimal IOP
6. Rarely the eye may become smaller i.e. progress to atrophic bulbi
IT IS VERY IMPORTANT FOR THE PATIENT TO UNDERSTAND THAT THE PROCEDURE IS NOT MEANT TO IMPROVE THE VISION OVER & ABOVE WHAT HE/SHE HAS ALREADY GOT.

I have been made aware of the above mentioned facts and I have been counseled about the potential benefits and possible side effects of the procedure and by thoroughly going through all of the above, I give my full informed consent for the above procedure.

Signature / Thumb Impression of Patient/ Parent / Guardian: ........................................................................................................................................................................

Name: ........................................................................................................................................................................ Relationship

........................................... Date  .........................

Address:

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Phone (Off) .................................................. (Res) .......................................................... (Mob)

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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1

Signature: ..........................................................  Name: ..........................................................

Address: ..........................................................  Tel: ..........................................................

Witness 2

Signature: ..........................................................  Name: ..........................................................

Address: ..........................................................  Tel: ..........................................................

Argon Laser Trabeculoplasty (ALT)
The argon laser causes photocoagulation of tissue. Thermal disruption of structural molecules, especially protein denaturation, results in tissue changes that are observed such as contraction, condensation, and separation. Formation of amorphous gels as well as clot formation can also occur. Higher temperatures result in non-selective coagulation necrosis of the target tissue and will lead to the burning of tissue.

**Argon Laser Trabeculoplasty**

Laser trabeculoplasty (LTP) is indicated for the treatment of open-angle glaucomas and is particularly effective in the treatment of pigmentary and pseudoexfoliation glaucomas. LTP causes alteration of the TM by photocoagulation and a greater effect is seen with more heavily pigmented TM. The precise mechanism of action is unknown but it relates to the change in conformation of the TM by collagen shrinkage leading to the opening of meshwork in adjacent, nontreated regions.

**Procedure**

A slit lamp-mounted argon laser is usually used with the laser beam focused at the outflow angle with a contact lens such as a Goldmann three-mirror lens. The laser settings are typically 800 mW to 1200 mW for 0.1 second and a 50-µm spot size. The laser is focused on the TM and the power adjusted to cause a slight focal bubble or blanching of the TM. The TM is treated for 180° to 360° with a total of 50 to 100 spots. Treatment complications include elevation of IOP, inflammation, inadvertent treatment of the cornea or ciliary body, hemorrhage, and pain.

**Antiglaucoma Medication History**

I have been explained about the procedure and the risk involved in the procedure in my own language. I have been explained that there might be decrease in vision, corneal burn, raised IOP, and IOP may not decrease to desired level. Knowing all these inadvertent complications, I am willing to undergo the above procedure and I give my consent for the procedure.
**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: ................................................
Name: ....................................................
Address: ..................................................
Tel: ......................................................

**Witness 2**

Signature: ................................................
Name: ....................................................
Address: ..................................................
Tel: ......................................................

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**Laser Iridotomy**

_Deepankur Mahajan_

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**Name of Patient** ........................................
**Age/Sex** ....... **Patient ID** .................... **Date** ....................

Son / Daughter of ............................................................................................................................

Address ............................................................................................................................................

Tel. ..................................................................................................................................................

Laser iridotomy is a procedure used for patients with narrow angle glaucoma in which a laser is used to make a small hole in the iris (colored part of the eye) to allow free movement of fluid from posterior to anterior chamber of the eye which might help to control the intraocular pressure and hopefully prevent scar formation between the iris and cornea which can check progression of the glaucoma.

Risks associated with this procedure include transient blurring of vision, post laser IOP spike, anterior uveitis, pupillary distortion, corneal epithelial defects and corneal burns, bleeding/hyphema, cataract, diplopia, late iridotomy closure, retinal/macular burns, malignant glaucoma, sterile hypopyon, cystoid macular edema and
pupillary pseudomembrane. Additional medical or surgical intervention might be required for these complications.

The procedure may require more than one sitting for completion in some cases. Some individuals respond only partially or not at all to the procedure and may require additional medication/surgical intervention to check progression of glaucoma.

Post procedure topical medication including glaucoma medication might have to be continued/changed.

I, .......................................................... have been fully explained in the best understood language (........................................) that I have RE/LE ................................................... and have to undergo right/left eye laser iridotomy for the same.

The details of the procedure, alternatives and their risks and benefits have been explained to my satisfaction. I hereby give my full, free and voluntary informed consent for right/left eye laser iridotomy.

Signature / Thumb Impression of Patient/ Parent / Guardian: ..................................................................................................................

Name: .......................................................... Relationship .................................. Date ....................... ..........................

Address: ...........................................................................................................................................

Phone (Off) ........................................................ (Res) ........................................................ (Mob)

Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: .......................................................... Name: ..........................................................
Address: .......................................................... Tel: ..........................................................

Witness 2
Signature: .......................................................... Name: ..........................................................
Address: .......................................................... Tel: ..........................................................
Introduction:
A cataract is opacity of the lens. Cataract operation is indicated only when you cannot function adequately due to poor sight produced by the cataract. Maturity of cataract is no longer a criterion for surgery. The natural lens within your eye with a slight cataract, although not perfect, has distinct advantages over an artificial lens.

In giving permission for cataract extraction with / without implantation of an intraocular lens in my eye, I declare that I understand the following information

1. Alternative Treatments:
   There are three methods of restoring vision after cataract surgery
   a) Cataract Spectacles b) Contact Lens c) Intraocular Lens
   Cataract spectacles increase image size by 30%. They cannot be used if there is cataract in only one eye (the other is normal) because they may cause double vision. A contact lens increases image size by 8%. However, it is difficult to handle and may not be tolerated by everyone. Intraocular lens does not increase image size. It is surgically placed inside the eye permanently.

2. An intraocular lens is implanted by surgery (not by laser). The implanted lens will be left in the eye permanently. At the time of surgery the doctor may decide not to implant an intraocular lens in the eye, if for any reason he feels that the lens implantation is not indicated or may prove deleterious to the well being of the eye, even though permission may have been given to do so.

3. Though the intraocular implant power is calculated by utilizing a computerised Biometer (A-scan), a small correction in the spectacles is to be considered inevitable postoperatively and this may be more in specific cases. An astigmatism (number with axis) which may reduce with time, is to be taken as inevitable and normal. Therefore, a small power is to be expected in the spectacles for distance and near for clear vision after the operation. In any case, the aim of cataract surgery is to remove the cloudy lens from the eye and replace it with a plastic lens and not to rid the patient of his spectacles.

4. The calibre of vision obtained after a successful cataract surgery/lens implantation depends upon the retina behind. In an advanced cataract even with the most sophisticated instruments (Ultrasound Scan etc.), it is not possible to be certain that the retina inside is normal. Removal of cataract is like opening a
5. With modern instrumentation and micro surgical techniques, the rate of complications in cataract surgery with/without intraocular lens implantation is very low. Complications can usually be managed by medical and/or surgical treatment. The chances of total loss of vision are less than 0.5%. However, the following complications can occur and are mentioned in standard text books of cataract and lens implantation surgery.

a) It is possible that vision may drop after surgery due to thickening/opacification of the posterior capsule. This is not a complication but a sequelae to Extra Capsular Cataract Extraction. The condition is treated with the “Yag Laser”

b) Complications may include haemorrhage (bleeding), posterior capsule rupture, nucleus drop, vitreous loss, wound leakage, uveitis, corneal decompensation, glaucoma, cystoid macular oedema or retinal detachment. In addition lens implantation may be complicated by severe reaction to the lens (Toxic Lens Syndrome) or dislocation of the lens. The implanted lens may have to be repositioned or removed surgically if it is likely to damage the eye. Though every effort is made to minimize the chances of infection, it cannot be eliminated altogether. Loss of vision is a risk common to any intraocular surgery.

c) Although you may have opted for phacoemulsification surgery and the same may have been planned by your surgeon after pre operative examination, if during surgery phacoemulsification is found to be unsafe or not feasible, your surgeon will have the liberty to perform surgery by the conventional technique in the interest of patient safety.

d) Complications of surgery in general: As the procedure is generally done under local anaesthesia the risk to life is less than 0.5%. Risk is greater in patients with Diabetes, Hypertension, Cardiac ailments and other systemic disorders & when surgery is performed under general anaesthesia. There is a possibility of drug reaction, brain damage or risk to life.

Since it is impossible to state every complication that may occur as a result of surgery, the list of complications in this form is not exhaustive.

**Consent for Operation**

1. I hereby authorize Dr. ............................................................. and those whom he may designate as associates or assistants to perform cataract operation with an intraocular lens / without an intraocular lens / as a secondary procedure on my left / right eye.

   It has been explained to me that during the course of operation/ procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other procedures in addition to or different from those contemplated. I, therefore, further request and authorize the above named Physician/Surgeon or his designates to perform such additional surgical or other procedures as he or they deem necessary or desirable.

2. The nature and purpose of the operation, the necessity thereof, the possible alternative methods of treatment of my condition have been fully explained to me and I understand the same.

3. I am fully aware that the surgery is being performed in good faith and that no guarantee or assurance has been given as to the result that may be obtained.

4. I consent to the administration of anesthesia and to the use of such anesthetics as may be deemed necessary or desirable.

5. I further consent to the administration of such drugs or infusions deemed necessary in the judgement of the medical staff.

6. I consent to the observing, photographing or televising of the procedure to be performed for medical, scientific or education purpose provided my identity is not revealed by the pictures or by descriptive text accompanying them.
7. Any tissues or parts surgically removed may be disposed off by the institution in accordance with customary practice

Informed Consent for Operation on Patients With Guarded / Poor Visual Prognosis

I have been explained by the attending surgeon/Designated Assistant prior to the operation that visual prognosis after surgery is guarded/uncertain/poor/very poor. The reasons for this have been explained to me. The reasons are: (to be signed by the patient / person authorised to consent for the patient.)

Trauma / Diabetic Retinopathy / Myopia / Glaucoma / Uveitis / Age Related Macular Degeneration / PVR / Complex Traction Retinal Detachment/Combined tractional rhegmatogenous retinal detachment/Dislocated lens or IOL / Endophthalmitis (Severe eye infection)

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Signature of patient / person authorised to consent for patient: ............................................................

I THE UNDERSIGNED (THE PATIENT OR NEAREST RELATIVE) HEREBY GIVE MY CONSENT FOR THE OPERATION OF LEFT EYE / RIGHT EYE WITH THE FULL KNOWLEDGE OF POSSIBLE COMPLICATIONS AND GUARDED / POOR VISUAL PROGNOSIS. I CERTIFY THAT I HAVE READ THIS INFORMED CONSENT / IT HAS BEEN READ OVER TO ME AND EXPLAINED TO ME IN MY MOTHER TONGUE AND ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND ANY INAPPLICABLE PARAGRAPHS STRICKEN OFF BEFORE I SIGNED. THE DOCTOR HAS ANSWERED ALL MY QUESTIONS TO MY SATISFACTION.

Signature / Thumb Impression of Patient/ Parent / Guardian:

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Name: ......................................................................................................................................................... Relationship
......................... Date .........................
Address:
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Phone (Off) ............................................................... (Res) ................................................................. (Mob)
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature
Pediatric Cataract

Shalini Mohan, Anand Aggarwal

Name of Patient ...........................................  Age/Sex ........ Patient ID ..........................  Date ............................... Son / Daughter of .........................................................................................................................

Address ............................................................................................................................... Tel.

Pediatric cataract may affect one or both eyes of children in any age group. Some children have cataract at birth where as some can get it during their developing years. The need for surgery is undertaken on the discretion of the ophthalmologist after a thorough assessment of child’s visual behaviour. If the cataract is visually significant, then early surgery is the best option for improving visual outcome and giving the child binocular vision. The surgery is performed under general anesthesia and whether or not the intraocular lens is placed at the time of primary surgery, depends on the age of the child and the laterality of cataract whether unilateral or bilateral. If both the eyes need to be operated, then two separate requirements for anesthesia are needed and the time for second eye is decided by the ophthalmologist after seeing the response of the first eye. It is very critical that clear ocular media is ensured so that the child can develop full visual potential.

Post operative care

The eye may be red, swollen and painful following the procedure for which pain relieving oral medications and some eyedrops are given to bring about relief. The medications may need to be used for a prolonged period after the procedure to ensure maximal efficacy of the procedure. It is very important for the child’s parents / legal guardians to understand that their role in the optimal visual outcome is as paramount as the ophthalmic physician. They need to ensure regular follow up of the child, to make note of abnormal visual behaviour, the need for regular examinations under anesthesia due to the changing refractive errors as the pediatric eye grows over time. Sometimes children may have other associated ocular and systemic abnormalities accompanying their cataract which might need additional surgical interventions/ systemic pediatric evaluation.
Post operative course & complications

1. After cataract and membrane formation: The incidence has decreased in recent years with the availability of modern techniques of surgery but can still occur especially in small children under the age of one year.

2. Changing refractive errors and the frequent need of glasses: Periodic assessment of child’s refractive status is a must for which repeated examinations under anesthesia are needed to ensure proper refraction. It is also important for the parents/ legal guardians to realize that they ensure that the proper refractive correction in the form of glasses/ contact lenses is worn by the child during waking hours.

3. Amblyopia (lazy eye) treatment: This is the single most important factor in the success of unilateral cataract cases. The parents/ legal guardians need to ensure that the child is on proper occlusion therapy, the frequency of which is decided by the treating ophthalmologist.

4. Glaucoma: This is the single most important cause of late onset visual loss after successful pediatric cataract surgery. The rate of this complication varies widely. To ensure safety, it is very important for the parents’/ legal guardians to ensure that periodic Intra ocular pressure of the child’s eye is monitored so that early detection is possible and remedial measures can be undertaken.

5. Retinal detachment/ endophthalmitis: These are rare complications.

6. Strabismus (squint) and nystagmus: These may sometimes be present at the time of presentation. Both of these require separate surgical intervention usually at a later date.

It is very important for you to realize that meticulous regular life long follow up is very important on your part so that the treating physician is able to assess your child’s visual function and early detection of any complication as listed above is possible.

I have been made aware of the above mentioned facts and I have been counseled about the potential benefits and possible side effects of the procedure and by thoroughly going through all of the above, I give my full informed consent for the above procedure on my child.

Signature / Thumb Impression of Patient/ Parent / Guardian: ...........................................................................................................................

Name: ........................................................................................................... Relationship ........................................................................................................

.............................. Date  .........................

Address: ..........................................................................................................................

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Phone (Off) .......................................................... (Res) .................................................. (Mob)

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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name
**YAG Capsulotomy**

*Deepankur Mahajan*

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Age/Sex</th>
<th>Patient ID</th>
<th>Date</th>
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Son / Daughter of

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Posterior capsular opacification (PCO) is a condition which develops due to clouding of back membrane of the lens left behind following modern cataract surgery to support the intraocular lens. Such a membrane causes blurring and dimunition of vision and occasionally streaks or haloes around light.

Laser capsulotomy involves using Nd-Yag laser to make a central hole within the PCO when it is causing significant complaints to the patient thereby providing a clear central visual axis to the patient.

Complications of the procedure include: Damage to IOL optic, IOL pitting, IOL subluxation, IOL dislocation, postoperative intraocular pressure elevation, new floaters/ spots, cystoid macular edema, retinal swelling, retinal detachment and exacerbation of localized endophthalmitis. Additional medical/surgical intervention may be required for these.

Alternative treatment options include surgical posterior capsulotomy whereby eye has to be opened to remove opacified posterior capsule.

I, .................................................. have been fully explained in the best understood language (........................................) that I have RE/LE posterior capsular opacification and have to undergo right/left eye Yag laser posterior capsulotomy for the same.

The details of the procedure and alternate treatments and their risks and benefits have been explained to my satisfaction. I hereby give my full, free and voluntary informed consent for a posterior capsulotomy in my right/left eye with the YAG laser.
Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ...........................................................................................................................................................................
Relationship ..............................................................................................................................................................
Date ...........................................
Address:
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Phone (Off) ...................................................... (Res) .............................................................. (Mob)
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**Declaration by Doctor**

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

**Witness 1**

Signature: ............................................................
Name: ............................................................
Address: ............................................................
Tel: ............................................................

**Witness 2**

Signature: ............................................................
Name: ............................................................
Address: ............................................................
Tel: ............................................................

**MISCELLANEOUS**

**Examination Under Anesthesia (EUA)**

_Chaitali Basu_

Name of Patient .............................................. Age/Sex ........... Patient ID .......................... Date
..............................................................................................................................................................
Son .............................................. Daughter of
..............................................................................................................................................................
I have been informed in the language I understand best, that my daughter/son/……... is to undergo Examination Under Anaesthesia (EUA), and that:

• The procedure is being done to thoroughly examine the patient who is not otherwise cooperative for normal examination.
• During examination, if any need for an intervention is felt by my doctor, I give my consent for performing any procedure as may be deemed advisable. I hereby certify that I have fully understood the reasons why the above procedure is considered necessary, its advantages and possible alternative modes of treatment. I also hereby certify that no guarantee or assurance has been made as to the result that may be obtained.
• The procedure carries all the inherent risks of General Anaesthesia. The risk of complication with serious after effects and/or death, though small is always present.

Knowing this I give my full, free and voluntary consent.

Signature / Thumb Impression of Patient/ Parent / Guardian:
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Name: ................................................................................................................................. Relationship
.............................................. Date  ............................
Address: ..................................................................................................................................................................................
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Phone (Off) ............................................................... (Res) .................... ........................................... (Mob)
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Declaration by Doctor

I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

Witness 1
Signature: .................................................................
Name: ..............................................................................

Witness 2
Signature: .................................................................
Name: ..............................................................................
Optical Iridectomy

Asim K. Kandar

Name of Patient ................................... ...........  Age/Sex ........ Patient ID ......................... Date ........................................

Son / Daughter of ..............................................................................................................................

Address ........................................... ................................................................ Tel.

I have been informed in my mother tongue that I/ my child is suffering from whitening of the cornea (Corneal opacity) with some clear area remaining (specify ..................................................) and that a surgery will be performed to enhance the passage of light through the clear area. A part of the iris (diaphragm of the eye) will be excised during the surgical procedure.

I have been fully explained regarding the permanent nature of the opacity/ lesion and that it may increase after the surgery and corneal transplant may be required. I have been explained the risk of development of cataract, leading to cataract surgery and lens implantation. There is risk of infection, hyphema due to haemorrhage from iris vessels leading to secondary rise of intraocular pressure. There is chance of no improvement or worsening of best corrected visual acuity, glaucoma secondary to surgery or to medications, and high astigmatism after surgery. There may be a need for repeat surgery which may or may not lead to improvement of vision. I have been explained the need for follow up as frequently as advised by the doctors that may span upto years, with multiple investigations at each visit. I have been explained that using medications properly is required for success of the procedure. I have been explained that I will need to urgently come for follow-up to ophthalmic casualty if there is sudden onset of redness, photophobia, pain or deterioration of vision as these may be signs of endophthalmitis. I understand that inspite of all efforts, there is a possibility that there may be worsening of the visual acuity or the cosmetic appearance of the eye.

I certify that I have fully understood the implications of the above consent and authorise the doctors to perform Optical Iridectomy on my/ my child’s right / left eye.

Signature / Thumb Impression of Patient/ Parent / Guardian: ..................................................................................................................................................................................

Name: ................................................................................................................................. Relationship ......................... Date ..................

Address: .................................................................................................................................

Phone (Off) .................................................. (Res) .................................................. (Mob) ........................................................................

Declaration by Doctor
I declare that I have explained the nature and consequences of the procedure to be performed, and discussed the risks that particularly concern the patient.

I have given the patient an opportunity to ask questions and I have answered these.

Doctor’s signature

Doctor’s name

Date

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