

**PATIENT INFORMED CONSENT TO UNDERGO LASEK
(Laser Assisted Epithelial Keratomileusis)**

You are entitled to be informed about the proposed LASEK treatment for the correction of your short or long sight with or without astigmatism, including the risks of the treatment and the alternatives. Please read this document carefully (or have it read to you) and discuss the content with your operating surgeon, so that all of your questions are answered to your satisfaction.

This document should be read in conjunction with your 'Information for Patients Considering LASEK' document, so that you can make an informed decision regarding the use of the Eximer laser to treat your short sight with or without astigmatism.

LASEK is a method of reshaping the cornea by means of an eximer laser. The superficial cells of the cornea (epithelium) are loosened with an alcohol solution and temporarily moved to one side of the surface of the eye exposing the underlying corneal layer. The laser is then applied and the epithelial cells are gently replaced over the central cornea. LASEK aims to reduce the need for spectacle or contact lens correction. The treatment is permanent.

The main benefit of Lasek is that no corneal incision is made. It is impossible to state every possible complication that may occur following surgery and therefore those complications stated in this consent form do not form a complete or exhaustive list.

In giving my permission to undergo LASEK treatment, I declare that I have read, understand and accept the following information:

1. I understand that the treatment involves the surgical creation of a film of epithelial tissue. The epithelium is the very front outer protective layer of the cornea. The laser is then applied to the next exposed layer of tissue. The laser removes tissue in order to reshape the cornea, correcting my particular refractive error.

Initial.....

2. I am aware that there are other ways of correcting my short or long sight. Most commonly by spectacles or contact lenses. Other available techniques to correct short sight include Radial Keratotomy, PRK, LASIK, Intacts (rings placed inside the cornea), lens replacement.

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3. I understand that in some patients, it may not be possible to move the epithelial film intact. The surgeon may be required to discard this tissue and revert to a PRK treatment, where there is no replacement of the loosened epithelial cells. It is not possible to discern prior to treatment whether the epithelium can be moved intact but reversion to a PRK treatment is very rare.

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4. I understand that the final outcome of this procedure is dependant on the individual healing process of each patient and this may result in under or over correction of my short or long sight/astigmatism. I also know that although visual results are reasonably predictable, the final amount of correction cannot be absolutely guaranteed.

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Over time, regression may occur which means some short sight/astigmatism reoccurs. It is possible therefore that I may still require glasses or contact lenses or require further laser surgery (enhancement procedure) in order to obtain the best vision possible. Enhancement procedures are required in a minority of patients to achieve their best results. However, not all eyes are suitable for an enhancement procedure, it is essential to consider the amount of remaining corneal tissue and stability of the cornea. I understand that it is possible that I may not be able to undergo an enhancement procedure and that full correction of my refractive error may not be achieved.

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5. I understand that there may be short term and long-term side effects of this procedure, as described in my 'Information for Patients Considering LASEK' document and whilst short term side effects, which may include pain, blurred vision during the healing process, dry eyes, and glare tend to cause no long-term visual problems, the following long term problems have been encountered; scarring or haziness of the cornea, glare, haloes or a 'starburst' effect around bright lights, under or over correction requiring spectacle or contact lens wear. Some of these conditions in their severest form, although rare, may produce a reduction in vision which may not be improved by wearing glasses/lenses or by undergoing further treatment.

Initial.....

6. I understand that there is a risk of developing an infection or inflammation during the healing process. The incidence of infection and inflammation, although very small, is greatest during the first three days and if severe, may result in scarring. Scarring may or may not affect the quality of my vision. If having both eyes treated at the same time, if an infection occurs in one eye after treatment, the risk of contracting an infection in the other eye is very high. I agree to comply with my aftercare advice regarding protecting my eyes and will take my antibiotic drops as prescribed.

Initial.....

7. I understand that the quality of vision in low light may not be as good as in bright light. This is particularly true of people with high levels of short or long sight with or without astigmatism or with people whose pupils are quite large. This may be a temporary side effect following treatment and usually settles within the first few weeks. Occasionally this is a permanent condition which cannot be corrected with further treatment or with glasses/contact lenses. Rarely, but it is possible, night time driving can become permanently difficult.

Initial.....

8. Excessive thinning of the cornea after treatment can leave the cornea vulnerable to future injury and a condition called 'ectasia'. Ectasia is rare but over time, if too much tissue has been removed from the cornea at the time of the procedure, the normal pressure inside the eye pushes the thin cornea forwards which can permanently damage the eye and will require further extensive surgery. That is why we take corneal thickness measurements prior to surgery. Very rarely, ectasia occurs without excessive thinning of the cornea.

Initial.....

9. I understand that the quality and quantity of vision achieved following surgery may not be as good as that which I achieved before surgery (loss of best corrected visual acuity). This may be due to an irregular corneal shape resulting from infection, inflammation, flap complications or scarring.

Initial.....

PATIENT DECLARATION

10. (Female only) I am not pregnant or breast-feeding. I understand that pregnancy could adversely affect my treatment results.

Initial.....

11. I understand that is important for me to declare any medical/psychological condition, including depression, which may affect the outcome of my treatment as indicated on my medical questionnaire. I have left my contact lenses for the required time prior to my examination and treatment. I understand that the wearing of contact lenses prior to treatment may adversely affect the outcome of surgery.

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12. I understand this treatment is an elective procedure and that I do not have to have this treatment. I understand that LASEK treatment is not reversible.

Initial.....

13. I give permission for the medical data concerning my operation and any subsequent treatment to be submitted for outcome data analysis and research. I understand that my identity will be kept strictly confidential in any reports or journal articles.

Initial.....

14. I understand and accept that full correction of my refractive error may not be achievable.

Initial.....

15. I understand the risks and benefits of treatment '

Please write statement 16 in your own handwriting in the box below.

In signing this Informed Consent form for LASEK, I am stating that I have read this document in addition to the 'Information for Patients

**Considering LASEK' document (or they have been read to me)
I fully understand and accept their terms and the possible risks,
complications and benefits that can result from LASEK.
Although it is impossible to state every possible complication that may
occur following surgery, the Surgeon has answered all of my questions to
my satisfaction.**

**My decision to undergo LASEK has been my own and has been made
without duress or inducement of any kind. I understand that I can
change my mind about having treatment at any stage throughout the
process.**

ADDITIONAL NOTES OR COMMENTS:

(If this space has not been used at the time of consent, surgeon please score through
this space so that alterations may not be made post patient consent)

EYE(S) to be Treated: **RIGHT EYE LEFT EYE BOTH**
(please circle)

Patient name.....

Signature of patient..... Date.....

Name of surgeon..... Date of Treatment.....

Signature of surgeon.....