

**REFRACTIVE KERATOTOMY
WITH CORNEAL OR LIMBAL RELAXING INCISIONS CONSENT**

1. REFRACTIVE KERATOTOMY INVOLVES PLACING CUTS ON THE SURFACE OF MY EYE. THESE CUTS FLATTEN STEEP AREAS OF MY CORNEA SO THAT MY VISION MAY BE IMPROVED, REDUCING MY DEPENDENCE ON GLASSES FOR DISTANCE VISION.

2. DURING SURGERY, MY DOCTOR WILL PERFORM REFRACTIVE KERATOTOMY ON MY EYE, UNLESS CONTRAINDICATED.

COMPLICATIONS OF REFRACTIVE KERACTOTOMY

1. AS A RESULT OF SURGERY, IT IS POSSIBLE MY VISION COULD BE MADE WORSE DUE TO DISTORTION FROM IRREGULAR HEALING OF THE CORNEAL AND/OR LIMBAL INCISIONS. I UNDERSTAND THE WEARING OF A CONTACT LENS, IN THIS INSTANCE, MAY NOT AFFECT USEFUL VISION.

2. I UNDERSTAND THERE IS A 1-250,000 CHANCE OF VISUAL LOSS DUE TO INFECTION THAT IS UNCONTROLLED BY ANITBIOTICS OR ANY OTHER MEANS.

3. IT IS POSSIBLE THAT DESIRED RESULTS MAY NOT BE OBTAINED INITIALLY, AND FURTHER SURGERY MAY BE NECESSARY AT A LATER DATE.

4. IT IS POSSIBLE THAT PERFORATION OF THE CORNEA COULD OCCUR EITHER DURING OR AFTER THE LIMBAL RELAXING INCISION IS PERFORMED AND THAT FURTHER SURGERY MAY BE NECESSARY AT A LATER DATE.

THE BASIC PROCEDURES OF REFRACTIVE KERATOTOMY SURGERY, ITS ADVANTAGES, DISADVANTAGES AND RISKS HAVE BEEN EXPLAINED TO ME. I AM STATING I HAVE READ THIS INFORMED CONSENT (OR IT HAS BEEN READ TO ME). I FULLY UNDERSTAND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM SURGERY. NO WARRANTY OR GUARANTEE HAS BEEN GIVEN AS TO THE RESULTS THEREOF.

PATIENT'S SIGNATURE _____

I AUTHORIZE AND DIRECT DR. _____, MY SURGEON TO PERFORM REFRACTIVE LENSECTOMY WITH CORNEAL RELAXING INCISSIONS (IF INDICATED) ON ME, USING TOPICAL/LOCAL ANESTHETICS AND/OR ANY THERAPEUTIC PROCEDURE WHICH HE MAY DEEM ADVISABLE FOR MY WELL BEING, WHETHER OR NOT ARISING FROM PRESENTLY UNFORSEEN CONDITIONS.

PATIENT'S SIGNATURE _____

PATIENT'S NAME (PRINTED) _____ DATE _____

WITNESS SIGNATURE _____

DOCTOR'S SIGNATURE _____