RETINA LASER PHOTOAGULATION INFORMED CONSENT FORM

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PATIENT'S
Name Surname:……...
Birthdate :…….
Hospital Admission Date:…….
Hospitalization Date:……
Protocol Number:……..
Telephone Number:……
Address:……
……

Information About Diagnosis:

..... You have consulted Eye Diseases Clinic upon your eye disease. Your right ……. left……. eye has/have been diagnosed with …… and a treatment is required.

Information About Treatment Method:

LASER PHOTOAGULATION Process is recommended for treatment of your diseased right ……. left……. eye

The aim of laser photocoagulation is to create a therapeutic burn by creating minimal damage to the surrounding tissue in a previously determined retinal area. Laser photocoagulation is used to treat vascular diseases of the retina, macular coroidal neovascular membranes, retinal tears and peripheral degeneration that may cause tear in the retina and some intracocular tumors. Before procedure, you will be applied eye drops that will dilute your pupils. Following topical anesthetic application and lens placement on the eye surface, laser application will be performed in the appropriate circles. If there is only local damage or edema, laser application is done only to that area. If the damage is not limited to only one area, laser can be applied to the entire retina for several sessions, except for the macular region. If necessary, laser application may be required again in an additional session. After the procedure, eye drop treatment is recommended for 3-4 days to prevent inflammation.

Treatment Prospects and Period:

Laser photocoagulation has a high chance of success. The processing time is short.

Complications and risks regarding treatment:

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1-Inflammation 2 - intraocular bleeding 3 - transient or persistent intraocular pressure elevation 4-Pain 5 - eye and tooth infection . Treatment of some of these complications is possible. Permanent vision damage may develop due to complications.

Complications that may be encountered if patient refuses to be operated:

1- According to your diagnosis, the progression of the underlying disease can cause decreased vision, eye pain, intraocular bleeding. 2 - You may lose sight completely.

Patient Consent:

I have read the above given information and have been informed by the undersigned doctor. I have been informed about the purpose, risks and complications of the intervention to be performed.

Your right (…….) I hereby allow Dr ..... to perform the **LASER PHOTOAGULATION** procedure planned to be performed to my Left (.....) eye.

I hereby sign this form consciously, without need for further explanation and under no pressure.

CONCLUSION:

I understand that medical practice is not a definitive science and ☐ results or treatment cannot be guaranteed.

I have been given detailed information about my condition, procedures to be applied and risks, and treatment options in the consent document and in my consultation with my doctor.

We state that we are aware of the responsibility in this matter, that we accept the suggested surgical intervention without any violence, threats, indoctrination, material or moral pressure, that we will not use the results of the surgery against each other as well as against the doctors and the hospital; that we will bear the consequences and therefore we

……
……
……

give consent to the operation suggested to me

PATIENT'S NAME :

DATE / TIME:

PATIENT'S SIGNATURE :

PROXY GIVER'S STATEMENT

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(IF THE PATIENT IS NOT ABLE TO GIVE CONSENT)

•I have read and understood the required explanations on the intervention to be performed, its results and risks.

•Since the patient is not able to give his/her consent, I hereby accept the operation by proxy.

PROXY GIVER'S NAME:
DATE/TIME:
SIGNATURE:

DOCTOR'S STATEMENT

•I hereby declare that I have made the necessary explanations on intervention to be performed and its results, and I have explicitly explained the risks that may take place regarding the patient.

•I have given patient the opportunity to ask questions and I have answered them.

DOCTOR'S NAME :
DATE/TIME:
DOCTOR'S SIGNATURE :

WITNESS' STATEMENT (preferably patient's relative)

I hereby approve that I have witnessed the explanation of this form and the discussion between the doctor and patient.

WITNESS' NAME :
DATE/TIME:
WITNESS' SIGNATURE :