INFORMED CONSENT

EPITHELIUM SCRAPING & NEEDLING

INTRODUCTION

This document is provided to obtain your informed consent for epithelium scraping and needling. It contains important information detailing the risks and benefits as well as alternative treatments available.

It is important that you thoroughly read and understand everything, and only sign once you have read, understood, and have had all questions answered to your satisfaction enabling you to make an informed decision.

INSTRUCTIONS

- You must review this entire document prior to treatment.
- Take as much time as needed to read and understand this document prior to signing.
- Your doctor is available to answer any questions or concerns you have regarding this consent.
- This document must be signed prior to any treatment.
- You will sign this document in-person at Laser Eye Institute.
- You may request a copy of this document at any time.

ID: CG REV: E-20201014

INFORMED CONSENT FOR EPITHELIUM SCRAPING & NEEDLING

INDICATIONS AND PROCEDURE

This information is being provided to you so that you can make an informed decision about surgically treating recurrent corneal erosion syndrome (RCES). RCES is characterized by the repeated breakdown of epithelium and can cause moderate to sever eye pain, photophobia, lacrimation. Surgical treatment of RCES is warranted when mild-to-sever RCES has not responded to medical therapy or bandage contact lens wear treatment. Surgical treatment for RCES involves placing a topical anesthetic in the eye, then the loose epithelium is removed. After removal of any lose epithelium the surface of the cornea underneath the epithelium is burred and/or punctured with a tiny needle to allow epithelium to adhere properly.

ALTERNATIVES

There are other ways to treat mild-to-moderate RCES including: artificial tears, topical and oral medications, punctual plugs, bandage contact lenses, and combination therapy. Depending on the severity of the RCES and response to other methods of treatment surgical intervention may be warranted.

RISKS AND COMPLICATIONS

There may be other risks not know at this time, which 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 event to the extent of making your vision worse or total loss of vision.

I have received no guarantee as to the success of my particular case. I understand that the associated risks.

It is possible that the introduction or spread of infection may occur which may lead to visual impairment.

Even with successful treatment it is possible that additional erosion will occur, possibly requiring additional treatment.

Corneal scaring may occur after treatment, this may cause vision to worsen.

Blurry vision and glare may occur as a result of treatment causing your vision to worsen.

I understand that I must not drive until I am certain that my vision is adequate for driving.

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.

INFORMED CONSENT

By signing the below, I certify the following to the best of my knowledge:

All 3 pages of this document have been given to me in its entirety. I have been given this document in advance of being asked to sign it.

All of my questions regarding treatment have been answered to my satisfaction allowing me to give my informed consent.

I have read, understand, and hereby consent to: *Epithelial Scraping & Needling*

I understand that during the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed at my physician's discretion. These additional procedures may carry additional risks in addition to the risks outlined above.

I understand that no warranty or guarantee has been made to me regarding the result, cure, or safety.

I give my permission for Laser Eye Institute to videotape or photograph my procedure for purposes of documentation, education, research, or training. Additionally, I give my permission for Laser Eye Institute to use data about my treatment to advance the field of laser vision correction. I understand that my name, or any other personally identifiable information will remain confidential unless I give subsequent written permission for my identity to be disclosed.

MY SIGNATURE BELOW FURTHER CERTIFIES:

TO THE BEST OF MY KNOWLEDGE I AM NOT CURRENTLY PREGNANT.

I AM NOT UNDER THE INFLUENCE OF ANY NARCOTIC, ALCOHOL OR ANY OTHER DRUG, OR SUBSTANCE THAT MAY IMPAIR MY JUDGEMENT OR MY ABILITY TO UNDERSTAND THIS CONSENT.

I WAS ABLE TO READ AND UNDERSTAND THIS INFORMED CONSENT. ANY QUESTIONS I HAD REGARDING THE ABOVE PROCEDURE(S), RISKS, BENEFITS, AND ALTERNATE PROCEDURES HAVE BEEN EXPLAINED TO MY SATISFACTION ALLOWING ME TO GIVE MY INFORMED CONSENT FOR THE ABOVE PROCEDURE(S).

Patient Name	Patient MRN	Date

Patient Email Address	Surgical Coordinator

Patient Signature