INFORMED CONSENT

LIMBAL RELAXING INCISION (LRI) ASTIGMATIC KERATOTOMY (AK)

INTRODUCTION

This document is provided to obtain your informed consent for removal of astigmatic keratotomy (AK), or limbal relaxing incision (LRI). 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.

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INFORMED CONSENT ASTIGMATIC KERATOTOMY

INDICATIONS AND PROCEDURE

Astigmatism is a condition that causes blurry vision. Normally, eyes are round (like a baseball). With astigmatism, the eye is long (like a football). Astigmatic keratotomy is a surgical procedure that aims to correct astigmatism by making small incisions on the surface of the eye. This reduces astigmatism by permanently changing the shape of the eye.

ALTERNATIVES

You could elect to not have your astigmatism treated surgically at this time. There are other methods to correct astigmatism without surgery, such as glasses or contact lenses; as well as other surgical options such as laser vision correction.

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. The long-term risks and effects are unknown. I have received no guarantee as to the success of my particular case.

Astigmatism may change or come back as you get older and cause blurry vision again.
Even with correction of astigmatism you may need to wear glasses or contacts to fully correct your vision.

Surgery may cause vision loss. It is possible your cornea may scar or become damaged resulting in further loss of vision. It may not correct all the astigmatism (under-correction), it could correct it too much (overcorrection), or change the type of astigmatism you have. If this occurs, you may continue to have blurry vision. You may need to wear glasses or have another procedure to make your vision clearer.

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. During healing fluctuations in vision may occur for up to three months, or sometimes longer.

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

Additional 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).

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: *Astigmatic Keratotomy*

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