

**AUTHORIZATION AND INFORMED CONSENT FOR
PHOTOTHERAPEUTIC KERATECTOMY (PTK)
AT THE SAN DIEGO EYE BANK**

TO: _____ Your physician is: _____ M.D.
(Patient Name)

Date of Surgery: _____ / _____ / _____

I. Right To Be Informed Of Risks And Right To Consent To Or Refuse PTK Procedure.

The San Diego Eye Bank (“Clinic”) maintains personnel, facilities and equipment to assist your physician in his or her performance of various surgical operations and other special diagnostic and therapeutic procedures, including Phototherapeutic Keratectomy (“PTK”). The PTK procedure that you have elected to undergo may involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guaranty is made as to result or cure. You have the right to be informed of such risks as well as the nature and purpose of the PTK procedure and the available alternative methods of treatment. This form is not a substitute for such explanations, which are provided by the above named physician.

II. Performance Of PTK Procedure.

Your physician has recommended the PTK procedure. PTK is a procedure in which a device called an excimer laser is used to remove corneal scars, reduce corneal irregularity, or treat painful corneal erosions. This procedure has been approved by the FDA. Upon your execution of this Authorization, the PTK procedure, together with any other procedures which, in the opinion of your physician, may be indicated due to an emergency, will be performed on you. The PTK procedure will be performed by the physician named above. Assistants, technicians and other persons in attendance during your PTK procedure may be Clinic employees. Such Clinic employees will, however, be acting pursuant to the express supervision and direction of your physician.

III. Patient Acknowledgment

PTK is an elective procedure. By signing this Authorization, you acknowledge that you have been informed by your physician or surgeon of the possible risks, complications and side effect associated with the PTK procedure, including, without limitation, the following:

1. During the procedure, the excimer laser could malfunction, requiring that the procedure be stopped before completion. Depending on the type of malfunction, this may or may not be accompanied by visual loss.
2. Irregular healing could result in a distorted cornea, corneal swelling, or blindness.
3. You may experience increased sensitivity to light, haze, glare, and fluctuations in the sharpness of your vision.
4. You may experience discomfort and blurred vision following the procedure.

5. If you have PTK performed on both eyes at the same time or in an interval of less than one week and any of the above complications occur in one eye, they may also occur in the other. This could result in significant loss of vision or even temporary or permanent legal blindness.

IV. Patient Consent

I have read this Authorization (or it has been read to me). The PTK procedure has been explained to me in terms that I fully understand, and I have had an opportunity to ask questions and receive satisfactory answers to any questions I have asked.

I have been informed about the possible benefits and possible complications, risks, and contraindications associated with the PTK procedure. I understand that it is impossible for my physician to inform me of every conceivable complication that may occur and that there may be unforeseen risks. I understand that no guarantee of a particular outcome was given that my vision could become better or worse following treatment, and that complications or a poor outcome may manifest weeks, months, or even years after the procedure.

My decision to undertake this procedure was made without duress of any kind. I understand that this procedure is an elective procedure.

I authorize the physician and other health care personnel involved in performing my procedure and in providing my pre-and post-procedure care to share with one another any information relating to my health, vision, or the procedure that they deem relevant to providing me with care. I also authorize my physician to use data about my procedure and subsequent treatment to further understand the procedure.

V. Patient Authorization and Consent

Your signature below constitutes your acknowledgment that:

1. You have read and agree to the foregoing;
2. The procedure set forth below has been adequately explained to you by your physician and that you have received all of the information you desire concerning such procedure; and
3. You authorize and consent to the performance of the procedure

Description of the procedure: _____

Dated: _____, Time: _____ AM / PM

Patient or authorized representative: **PRINTED NAME**

Patient or authorized representative: **SIGNATURE**

(If signed by other than patient, indicate relationship: _____)

I have been offered a copy of this Authorization (please initial) _____