AUTHORIZATION AND INFORMED CONSENT FOR LASER IN-SITU KERATOMILEUSIS (LASIK) 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 LASIK 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 Laser In-Situ Keratomileusis ("LASIK"). The LASIK 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 LASIK 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 LASIK Procedure.

Your physician has recommended the LASIK procedure. LASIK is a procedure in which devices called a microkeratome or an IntraLase laser, and an excimer laser, are used to reshape the cornea to reduce nearsightedness, reduce farsightedness, or astigmatism. Upon your execution of this Authorization, the LASIK 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 LASIK procedure will be performed by the physician named above. Assistants, technicians and other persons in attendance during your LASIK 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

LASIK 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 effects associated with the LASIK procedure, including, without limitation, the following:

1. During the procedure, the microkeratome, IntraLase laser or 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. The microkeratome or IntraLase laser incision could be too thick, too thin, or incomplete. If this occurs, it is likely that the excimer laser part of the procedure will have to be postponed until the cornea has a chance to heal sufficiently to try to perform the incision again.

3. Irregular healing could result in a distorted cornea, and the procedure could result in rare complications, including corneal swelling, retinal detachment, hemorrhage, arterial blockage, or blindness.

4. You may experience increased sensitivity to light, haze, glare, and fluctuations in the sharpness of your vision. While these conditions usually only occur during the normal stabilization period from one to three months, they may also be permanent.

5. An overcorrection or undercorrection could occur, requiring future procedures or the use of glasses or contact lenses.

6. There may be a "balance" problem between your eyes if the procedure has been performed only on one eye.

7. After the procedure, your eye(s) may be more fragile to trauma from impact.

8. You may experience discomfort and blurred vision following the procedure, and temporary glasses may be necessary while healing occurs.

9. Visual acuity gained from the procedure could regress, and your vision may go partially or completely back to the level it was immediately prior to undergoing the procedure.

10. If you have LASIK 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. Use of Microkeratome.

Your physician may elect to use his or her own microkeratome during your procedure. If your physician uses his or her own microkeratome, you acknowledge that (i) the Clinic is not providing the microkeratome, and (ii) the microkeratome will be operated by your physician or by staff acting under the direction of your physician, some of whom may not be Clinic employees.

V. Patient Consent

I have read this Authorization (or it has been read to me). The LASIK 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 LASIK 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 and my medical condition might be treated by alternative means, such as glasses, contact lenses, or other forms of refractive surgery.

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.

VI. 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): _____