# Consent Form 1

***Patient agreement to surgery for cataract removal and new lens implant Consent Stage 1***

## Patient details (or pre-printed label)

Patient's surname/family name _____

Forenames _____

Hospital Number _____

Date of Birth _____ /_____ /_____

Responsible Health Professional _____

Job Title _____

Hospital / Hospital contact details_____

_____

## Name of Proposed Procedure or Course of Treatment

*(use language which can be understood by the patient and include all procedures that may be necessary)*

Cataract removal and lens implant, please confirm which eye: RIGHT / LEFT

*Under General / Local Anaesthetic - delete as appropriate*

## Statement of Consultant/Health Professional

(to be filled in by Consultant/Health Professional with appropriate knowledge of the proposed procedure as specified in consent policy).

I have explained the procedure to the patient. In particular I have explained the intended benefit: To improve vision

Other benefits _____

Significant, unavoidable or frequently occuring risks

- **Common more than 1 in 20:** Need to wear spectacles, clouding behind new lens needing further treatment with a laser
- **Common up to 1 in 20:** Complications in surgery that can be treated then or later such as rupture of membrane behind cataract or some cataract left in the eye / High pressure within the eye needing temporary treatment (more common in glaucoma patients)
- **Uncommon up to 1 in 100:** Part of lens falling to the back of the eye, with the need for further surgery. Further surgery for other complications: Retina problems (detachment - more common in short sighted patients and / or fluid build-up/swelling). Inflammation or bleeding inside eye / worse vision / permanent mild loss of vision, that cannot be improved with glasses.
- **Rare up to 1 in 1000:** Infection inside eye / Glaucoma / Severe or permanent vision loss / Corneal swelling which fails to settle / Other complication e.g. pupil shape change.
- **Very rare up to 1 in 10,000:** Inflammation which could affect vision in both eyes, loss of eye. (There is no guarantee for visual outcome, this is not an exhaustive list – other complications can occur that can impair visual results)

**Material risks for this patient:** _____

_____

EIDO Leaflet provided ☒ Other Leaflet www.vempali.com ☑

Any extra procedures which may become necessary during the procedure_____

Unlicensed/off-label medicines may be administered as part of the procedure (verbal/written information provided CL-4292-000-R) ☒

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. ☒

Signed _____ Date _____ / _____ / _____

Name (PRINT) MR V M R VEMPALI Job Title CONSULTANT OPHTHALMIC SURGEON

## Statement of Interpreter *(where appropriate)*

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe she/he can understand.

Signed _____ Date _____ / _____ / _____

Name (PRINT) _____ Interpreter Reference Number _____



Hospital Copy

Surname _____ Forename _____ Hospital No. _____

## Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of the page which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form. **Please tick the box where you agree with this statement.**

**I agree** to the procedure or course of treatment described on this form and I have discussed and understand the benefits and risks. ☑

**I understand** that there is a serious risk to my health and risk to my life if I contract COVID-19 in the period around the time of my surgery. I have discussed these risks with a Doctor and wish to continue with my surgery at this time. ☑

**If undergoing a general anaesthetic, I understand** that I will have the opportunity to discuss the details of anaesthesia with a Consultant Anaesthetist before the procedure, unless the urgency of my situation prevents this. ☑

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health. ☑

**I confirm** I have received copies of information as listed. ☑

**I have** been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion. ☒

**I have** provided a copy of of my advance directive/living will, if applicable. ☐

Patient's signature _____ Date _____ / _____ / _____

Name (PRINT) _____ Job Title _____

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signed _____ Date _____ / _____ / _____

Name (PRINT) _____ Job Title _____

Copy of form accepted by patient YES / NO

## Consent Stage 2

### Confirmation of consent

On behalf of the team treating the patient, I have confirmed with the patient that there has been no change in medical condition. ☐

The patient confirms they have discussed with the anaesthetist the risks/benefits and alternatives regarding the anaesthesia they are to receive. ☐

She/he has no further questions and wishes the procedure to go ahead. ☐

Signed _____ Date _____ / _____ / _____

Name (PRINT) _____ Job title _____

### Important Notes *(tick if applicable)*

☐ Patient has withdrawn consent (ask patient to sign/date below)

Signed _____ Date _____ / _____ / _____