מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

מס' זהות:
שם משפחה: שם פרטי:
שם האב: תאריך לידה:
כתובת:
טלפון: **מדבקת פרטי מטופל**

טופס הסכמה: ניתוח לתיקון ליקויי ראיה על ידי אקסיימר לייזר

CONSENT FORM: PHOTOREFRACTIVE KERATECTOMY BY EXCIMER LASER (PRK)/ LASER-ASSISTED KERATO MILEUSIS (LASIK)

The operation is performed to improve visual acuity in cases of shortsightedness or longsightedness not by glasses or contact lenses. The operation is not intended to correct the basic problem and/or other eye diseases.
The operation is usually performed under local anesthesia by instilling drops into the eye/eyes.

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the operation for correction of sight by excimer laser in the method _____
_____on the left/right* eye (henceforth: "the primary operation").

It has been explained to me that the surgical alternatives for improvement of sight are: performing incisions in the cornea (RK); removal of layers on the surface of the cornea (PRK), removal of layers in the depth of the cornea (LASIK); removal of layers in the depth of the cornea by a different technique (LASEK); implanting a lens into the eye (IOL); removal of the transparent lens and implanting rings in the cornea and also removal of the natural lens and its replacement by an artificial lens. Their advantages and disadvantages and their suitability to my condition have been explained to me.
It has been explained to me that the success rates of the operation are higher when the shortsightedness is up to 7.0 diopters with or without astigmatism but nevertheless the possibility exists that the desired result will not be achieved, or that the visual acuity achieved after the operation will change. In such cases, improvement of vision will require additional treatment. The fluctuation and changes in the visual acuity usually continue for about three months, but in rare cases are also liable to continue for a longer period after the operation.
It has been explained to me that even if improvement has been achieved, there will sometimes be need for wearing glasses and in any case the operation does not free me from reading glasses. After the operation there is a need for medicinal treatment for a period of time to be determined by the physician. Prolonged treatment with drops is liable to cause the development of glaucoma or cataract. It has been explained to me that the operation is relatively new and its effects in the long run are not known.
I hereby declare and confirm that I have received an explanation concerning the side effects after the operation, including: pain, discomfort, dryness of the eye that continues for a number of months and sensitivity to sunlight and to strong light that expresses itself as glare and is liable to continue for a number of months and limit driving particularly at night.
I have received an explanation concerning the possible risks and complications of the primary operation, including: infection that is liable to cause irregular healing of the cornea, its deformation, and in very rare cases very defective sight up to complete loss of sight. Irregular healing of the cornea may also be due to other causes related to the operation. There may also be opacity of the cornea after the operation that is liable to cause blurring of vision and glare. There may also be slight drooping of the eyelid that reverts in most cases. In very rare cases irregular healing or protrusion of the cornea is liable to occur a year or more after the operation.

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Conditions exist in which over-correction of shortsightedness is liable to cause longsightedness and the need for the use of glasses. There are also conditions of limitations in wearing contact lenses after the operation.

I hereby give my consent to perform the primary operation.
I also give my consent for the performance of local anesthesia with the use of drops unless the surgeon decides otherwise.
If it is decided that the primary operation will be performed under general anesthesia, I will receive an explanation from an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law, and that the physician responsible for the operation will be**_____
Name of Physician

_____ _____ _____
Date Time Patient Signature

_____ _____
Name of Guardian (Relationship) Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I provided the patient / the patient's guardian* with a detailed verbal explanation of all the above mentioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

_____ _____ _____
Name of Physician Physician's Signature License No.

* Cross out irrelevant option.
** Fill in in the case of a private patient