

DISCLOSURE AND CONSENT
Medical and Surgical Procedure

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Dr. Amjad Khokhar, M.D.
as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: _____
Visually significant cataract (right eye / left eye)

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: Cataract extraction with implantation of intraocular lens and other procedures deemed medically necessary (right eye/ left eye)

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure: Complications requiring additional treatment and/or surgery, need for glasses or contact lenses, complications requiring removal of the implanted lens, partial or total loss of vision

If you consented to blood and blood products: fever, transfusion reaction which may include kidney failure or anemia, hepatitis, A.I.D.S. (acquired immune deficiency syndrome), heart failure, other infections

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

Date: _____ Time: _____ AM/PM Translated into: _____

By: _____
PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGN

Patient unable to sign due to: _____

SIGNATURE OF WITNESS
Sugarland Eye & Laser Center
NAME
3531 Town Center Blvd. #102
ADDRESS (STREET OR P.O. BOX)
Sugar Land, TX 7479
CITY, STATE, ZIP CODE