Valley Surgery Center

Cataract Procedure Consent

(A) I acknowledge and understand that the following procedures(s) which has (have) been described to me is (are) to be performed on the patient at Crescent City Surgery Center (the "Facility").

(B) DNR (Do Not Resuscitate) Order:

If I have consented to a do not resuscitate order ("DNR"), I UNDERSTAND AND ACKNOWLEDGE THAT my consent to a DNR order is temporarily suspended/canceled while I undergo any elective, invasive, interventional and/or operative procedure performed at this Facility. I WILL BE RESUSCITATED. This temporary suspension (cancellation) of a DNR order will remain in effect until I am discharged from the facility or transferred to a higher level of care.

(C) Photographs: I consent to the taking and publication of any photographs in the course of this operation for the purpose of treatment and/or medical education.

(D) Human Immunodeficiency Virus (HIV) and Hepatitis Testing; I understand that in the event a health care worker sustains a significant exposure to my blood or body fluids, I may be asked to undergo testing for HIV, the virus that causes AIDS, and/or hepatitis. The results of any test will be confidential and will be treated in accordance with applicable state and federal law.

(E) No Guarantees: I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

(F) Use/Disposal of Tissue: I hereby authorize the Facility to retain, photograph, preserve, and use for scientific or teaching purposes, or dispose of at its convenience any specimens or tissues taken from my body during my procedure or treatment. Specimens or tissues removed may be sent to a laboratory for further testing or examination by pathologist.

(G) I consent to the administration of anesthesia as required for the surgery. Should I have any questions regarding this, I will have the opportunity to discuss them with the anesthesiologist prior to surgery.

(H) Possible Complications of Surgery: As a result of any surgery to the eye, it is possible that my vision could be made worse. Complications may include, but are not limited to astigmatism, bleeding, failure to heal, infection, loss of corneal clarity, lid droop, loss of lens material into the eye, dislocated lens, detachment of the retina, glaucoma, double vision, asymmetry or the possible need for additional surgery. These and other complications may result in poor or total loss of vision, loss of the eye or subsequent admission to the hospital.

(I) I authorize the admittance of observer and/or Manufacturer's Representatives as deemed appropriate by my surgeon.

(J) Certification and signatures: I certify that I understand the information regarding my procedure and anesthesia and that I have been fully informed of the risks and possible complications thereof, as well as, medically acceptable alternatives to my procedure. I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. I hereby authorize and permit the physician and whomever he/she may designate as his/her assistants to perform upon me the named procedure(s).

If any unforeseen condition arises during the procedure calling in his/her judgment for additional procedures or medications, I further request and authorize him/her to do whatever he/she deems advisable.

I certify that I have been informed that I may receive a sedative for this procedure. I understand that I should not drive, operate machinery, make critical decisions, or drink any alcohol until the day after my procedure. I have signed this form prior to receiving sedation.

I voluntarily assume the risk of any injury damage to me and my unborn child if I am pregnant	yes, no, n/a
I understand that certain procedures and/or drugs may be harmful to an unborn child.	Yes, no, n/a
I refuse the facility urine pregnancy test	yes, no, n/a