Please Print Your Name: ______________________________

LASIK Consent Form

Please read the following carefully and sign:

The following presents the possible risks and complications of LASIK (Laser In Situ Keratomileusis) surgery and is provided to improve your understanding of its medical limitations and to initiate an open channel of communications between you and your physician. Your decision whether or not to have LASIK surgery should be based on the information presented in conversations with your doctor, other literature provided and the information on this form.

In giving permission for surgery, I declare that I understand the following:

1. LASIK is a procedure, which permanently affects the cornea with a laser and keratome (flap-maker).
2. There a no guarantees for the results of this procedure, however, the vast majority of patients achieve the desired goal of uncorrected visual acuity.
3. As a result of the surgery it is possible, although unlikely, that my vision may be made worse. This could happen as a result of infection, inflammation, unpredictable healing of the eye including an abnormal flap, equipment malfunction, misdirected laser beam, or other circumstance beyond the control of the surgeon, laser center or staff member of the center.
4. It may be necessary to wear glasses or contact lenses to achieve useful vision and that there is a possibility that this may restore useful vision. Additionally, it is possible that the desired results of surgery may not be obtained and that at a later date, it may be necessary to have further surgery (enhancement).
5. Conditions such as glare and blurred vision are rarely associated with LASIK and are mostly temporary, but may become permanent as a result of surgery.
6. After surgery, I may experience temporary discomfort, double vision, corneal swelling, foreign body sensation, shadow images, light sensitivity and tearing. This may affect my ability to drive and judge distances.
7. I understand that the results of surgery may vary from the intended results which lead to under-correction or over-correction, where some degree of nearsightedness, farsightedness or astigmatism may occur requiring the use of glasses or contact lenses. Additionally, I understand that varying results may increase my dependence on reading glasses or require the use of reading glasses at an earlier age. I might not be able to wear contact lenses after LASIK.
8. I understand that it is possible to incur unforeseen complications such as corneal deposits, inflammation of the iris, irregular astigmatism, itching, double vision, discomfort, light sensitivity, drooping of the eyelid, reading difficulty and corneal inflammation.
9. LASIK surgery can weaken the cornea in certain patients, such that progressive thinning (ectasia) can develop. This might cause decreased vision that cannot be improved with an enhancement. Contact lenses, glasses or corneal transplant might be therapeutic options in such cases.
10. As with all types of surgery, I understand that there is a possibility of drug reactions related to the eye drops.
11. I understand the information presented. Although it is impossible for my physician to inform me of every possible complication that may occur, my physician has answered all questions to my satisfaction.
12. I give permission for medical data concerning my surgery and subsequent treatment to be released to investigators, physicians and responsible authorities demonstrating a need for such information.
13. I give consent for further procedures to correct a complication that might arise, including but not limited to dislodged flap, inflammation, epithelial ingrowth and infection.
14. Please write down other questions or concerns: ______________________________

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I wish to have Laser In Situ Keratomileusis (LASIK) performed on my eye(s).

PRINT PATIENTS NAME ______________________________

PATIENTS SIGNATURE ______________________________

DATE ______________ TIME ____________ PLACE ______________________________

WITNESS' SIGNATURE ______________________________ DATE ______________

PHYSICAN'S SIGNATURE ______________________________ DATE ______________

Please Print Your Name: ______________________________

Directions:
Please answer the following True/False questions to ensure that you understand LASIK. Indicate your response by circling the answer you feel is most correct. Take as much time as you need on each question.

1. **TRUE OR FALSE**: Laser in Situ Keratomileusis (LASIK) is a procedure in which a corneal flap is created and an excimer laser is used to reshape the inner layers for nearsightedness or the area near the edge of the cornea for farsightedness.
2. **TRUE OR FALSE**: Other alternatives for improving nearsightedness, farsightedness and astigmatism besides refractive surgery include glasses, contact lenses or other laser procedures such as PRK or LASEK.
3. **TRUE OR FALSE**: LASIK is not associated with any risks or complications.
4. **TRUE OR FALSE**: LASIK has a long healing time.
5. **TRUE OR FALSE**: You will need to remove your contact lenses and switch to glasses prior to the LASIK procedure.
6. **TRUE OR FALSE**: No anesthetic or numbing drops are used prior to the LASIK treatment.
7. **TRUE OR FALSE**: Typically, you will experience very little pain or discomfort after the LASIK procedure.
8. **TRUE OR FALSE**: You dispose of your glasses or contact lenses after the procedure because there is no chance any amount of nearsightedness, farsightedness or astigmatism will appear after LASIK.
9. **TRUE OR FALSE**: People age 45 and older will likely need reading glasses whether they have had LASIK or not.
10. **TRUE OR FALSE**: If your eye(s) is under-corrected or over-corrected you may have another LASIK procedure known as an enhancement at your doctor's discretion.
11. **TRUE OR FALSE**: Impaired vision at night is not a possible side effect of LASIK.
12. **TRUE OR FALSE**: You will have only one follow-up appointment after your LASIK procedure.

Directions:
Please grade your own test by comparing answers to those you marked. Place an "X" next to any question you missed.

1. **TRUE**: Laser in Situ Keratomileusis (LASIK) is a procedure in which a corneal flap is created and an excimer laser is used to reshape the inner layers for nearsightedness or the area near the edge of the cornea for farsightedness.
2. **TRUE**: Other alternatives for improving nearsightedness, farsightedness and astigmatism besides refractive surgery include glasses, contact lenses or other laser procedures such as PRK or LASEK.
3. **FALSE**: As with any surgical procedure, LASIK is associated with risks or complications.
4. **FALSE**: LASIK does not have a long healing time.
5. **TRUE**: You will need to remove your contact lenses and switch to glasses prior to the LASIK procedure.
6. **FALSE**: Anesthetic or numbing drops are used prior to the LASIK treatment.
7. **TRUE**: Typically, you will experience very little pain or discomfort after the LASIK procedure.
8. **FALSE**: Some amount of nearsightedness, farsightedness or astigmatism may reappear after LASIK, which may require you to wear glasses or contact lenses.
9. **TRUE**: People age 45 and older will likely need reading glasses whether they have had LASIK or not.
10. **TRUE**: If your eye(s) is under-corrected or over-corrected you may have another LASIK procedure known as an enhancement at your doctor's discretion.
11. **FALSE**: Impaired vision at night is a possible side effect of LASIK.
12. **FALSE**: You will have several follow-up appointments after your LASIK procedure. Each one is very important.

PRINT PATIENTS NAME ____

PATIENTS SIGNATURE ______________________________ DATE ________________