

PRESTON PLAZA SURGERY CENTER

17950 Preston Road Ste 75
Dallas, TX 75252

DISCLOSURE AND CONSENT

Medical and Surgical Procedures

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. George Joseph, MD 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
as: _____

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 and trabulectomy left/right eye with implantation of intraocular lens and correction of astigmatism

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) (do) (do not) consent to photography/videography of my procedure.

I (we) (do) (do not) consent to visitors/vendors in the operating room during my procedure.

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:

- (A) Complications requiring additional treatment and/or surgery.**
- (B) Need for glasses or contact lenses.**
- (C) Complications requiring the removal of implanted lens.**
- (D) Partial or total loss of vision.**

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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 non-treatment, 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, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON

SIGN _____

Relationship to patient _____

A.M.

DATE: _____ **TIME:** _____ **P.M.**

WITNESS:

Name _____

Address (Street or P.O. Box, City, State, Zip Code)

A.M.

DATE: _____ **TIME:** _____ **P.M.**

PHYSICIAN SIGNATURE

SIGN _____

A.M.

DATE: _____ **TIME:** _____ **P.M.**