SLT LASER CONSENT

____ ____________________

PATIENT NAME DATE

DISCLOSURE AND CONSENT FOR 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 and diagnostic procedures 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. ____________________ 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
GLAUCOMA of the ____________ EYE

I (We) understand that the following surgical, medical and/or diagnostic procedures are planned for me and I (We) voluntarily consent andauthorize these procedures
LASER TREATMENT FOR GLAUCOMA of the ____________ EYE

I (We) understand that no warranty or guarantee has been made to me as a result or cure of my glaucoma. I understand that it is necessary to have my eye pressure checked regularly to ensure my glaucoma is under control. There is no guarantee that I will never need glaucoma drops now or in the future. 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 medical and/or diagnostic procedures planned for me. I (We) also realize that the following risks and hazards may occur in connection with this particular procedure:

- Transient Blurred Vision
- Transient Ocular Irritation and Inflammation
- Increased Intra-Ocular Pressure
- Complications Requiring Additional Treatment and/or Surgery
- Worsening of The Glaucoma
- Pain
- Partial or Total Loss of Vision

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

____________ ____________ ____

DATE TIME PATIENT SIGNATURE OR LEGAL GUARDIAN SIGNATURE

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WITNESS SIGNATURE

EYE CENTER OF TEXAS
Leaders in Eye Care