



Leaders in Eye Care

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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 and authorize 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:

1. **Transient Blurred Vision**
2. **Transient Ocular Irritation And Inflammation**
3. **Increased Intra-Ocular Pressure**
4. **Complications Requiring Additional Treatment And/Or Surgery.**
5. **Worsening Of The Glaucoma**
6. **Pain**
7. **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

Witness