ESC EYE SURGERY CONSULTANTS

Dr Dermot Cassidy
BSc (Hons) MBBS FRANZCO
Cataract, Corneal and Laser Refractive Surgeon

PHOTOTHERAPEUTIC KERATECTOMY (PTK)

Informed Consent Form for the Treatment of Corneal Disease

Please read this form carefully

If you have any questions or concerns
do not hesitate to contact Dr. Cassidy to discuss them

This should be done **prior** to the day of surgery

PATIENT NAME..... **DATE.....**

Phototherapeutic keratectomy (PTK) involves using the excimer laser to remove tissue from the surface of the cornea (the clear surface on the front of the eye). This is usually performed for the treatment of recurrent ulcers on the surface of the cornea (recurrent corneal erosion syndrome), to remove calcium or other deposits or scars on the surface of the cornea and to reduce pain from a swollen cornea prone to the formation of ulcers.

Typically patients experience significant discomfort to pain in the operated eye for several days following surgery and it usually takes days to several weeks for the vision to return to normal.

Occasionally following PTK patients may experience a small change in their glasses script.

IN GIVING MY PERMISSION FOR SURGERY I DECLARE THE FOLLOWING:

1. I understand that I may need additional treatment with the excimer laser.

2. I understand that rarely the effect of surgery may regress with time.

3. The results of surgery cannot be guaranteed and it is possible that my corneal condition may not be improved following surgery. I also understand that rarely complications such as a corneal infection or scarring could occur that could lead to a permanent reduction in my vision.

Suite 216-218, 2nd Floor, 100 Victoria Parade, EAST MELBOURNE 3002
Tel: (03) 9654 3500 Fax: (03) 9654 3533 Provider No: 237733HH
www.eyesurgeryconsultants.com.au

4. I understand that the standard follow-up examinations following PRK surgery are at several days and 1 month after treatment as well as any other follow-up examinations deemed necessary by my physician.

5. 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, on the basis that this information is confidential, my privacy will be protected and my name will not be used.

I wish to have a Phototherapeutic keratectomy (PTK) performed on my:

LEFT EYE: ..... **(initials)**

RIGHT EYE: ..... **(initials)**

I have read and understand the information in this form. Although it is impossible for my surgeon to inform me of every possible complication that may occur, and this list of potential complications is not complete, Dr. Cassidy has answered all my questions to my satisfaction with regard to possible side effects, complications and benefits that can result from the surgery.

Patient signature: _____ Date: ___ / ___ / ___

Witness signature: _____ Date: ___ / ___ / ___