Pacific ClearVision INSTITUTE
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INFORMED CONSENT FOR: PHOTOTHERAPEUTIC KERATECTOMY

Dr. _____ has described to me a procedure called Phototherapeutic Keratectomy (PTK). PTK is done by using the Excimer Laser, The Excimer laser is used to remove scars, smooth the surface of the cornea, treat cornea erosions, or change the shape of a cornea that has been distorted by injury or surgery. PTK removes the diseased portion of the cornea. This hopefully will improve vision and comfort of the eye.

PTK lasts anywhere from ten (10) seconds to five (5) minutes. I will be given a topical anesthetic to help ensure that there will be little to no discomfort during the procedure.

The surgeon will put medication in the treated eye and cover it with a contact lens. Following the procedure, there may be some degree of eye pain for a day or two, requiring medication prescribed by the eye doctor. I understand that I must be examined closely to assure proper healing of the treated eye.

Benefits:

1. Relief of pain or restoration of visual function.
2. The benefits of PTK cannot be guaranteed.
3. It is possible the procedure will be of no benefit and may be harmful.

Alternatives:

1. Living with my current condition.
2. Contact lenses.
3. Stromal punctures.
4. Selection of another surgical procedure such as a corneal transplant.

Complications and Risks:

1. Loss of sharp vision.
2. Increased corneal scarring.
3. Increased night glare.
4. Corneal infection.
5. If the cornea has extensive scars, it is possible that a corneal perforation may occur that could produce other changes such as infections, cataracts, or the need for additional surgery.
6. Any pre-existing viral infections may reappear with the use of post-operative drops.

I understand that I must be examined closely to assure proper healing of the treated eye.

I understand that I may choose to live with the limitations and symptoms caused by my condition, and that other surgical alternatives may be available to me. I further understand that the nature of corneal scars and irregularities are so diverse that it is not possible to discuss all possibilities in detail on this form. I have, however, discussed with the doctor the alternatives that may be available.

Patient Consent

In giving my permission for Excimer laser surgery, I have been advised by Dr. _____ and understand the items listed below:

1. The surgical removal of the superficial layers of my cornea using the Excimer laser has been elected by me as an alternative to other forms of corneal surgery.
2. As with all surgery, I understand the results cannot be guaranteed.
3. I understand PhotoTherapeutic Keratectomy (PTK) with the Excimer laser may increase my need for glasses and may require the use of corrective lenses to achieve my best vision.
4. I understand that although sharper vision and less glare are anticipated, it is possible that glare and clarity may be made worse following the procedure.

5. I understand that for those severe corneal problems, where the surgical option for me is a corneal transplant, Excimer laser PTK may not eliminate the need for a corneal transplant.
6. I understand that it is impossible to state every possible complication that may occur as a result of the surgical procedure.
7. I understand that not all beneficial effects of PTK are currently known.
8. I understand that not all the risks and complications are currently known.
9. I acknowledge this disclosure of information has been made to me, and that all my questions have been answered to my satisfaction.
10. I have read this form (or it has been read to me), and I fully understand the complications, risks, and benefits that can result from PTK surgery. I realize there are no guarantees with PTK surgery.

I still, however, elect to have PTK laser treatment on my: RIGHT LEFT eye. (Please circle)

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Physician Signature: _____ Date: _____