Laser Consent Form

I (we) voluntarily request Dr. Sunil Patel, Dr. S. Young Lee, Dr. Grant Janzen, Dr. Eric M. Zavaleta and/or Dr. Courtney M. Crawford as my physician, to treat my condition with the recommended laser treatment.
I (we) have been explained that I will be receiving a retinal laser treatment in the RIGHT EYE / LEFT EYE for:

- ❑ Proliferative Diabetic Retinopathy
- ❑ **MILD** Nonproliferative Diabetic Retinopathy
- ❑ **MODERATE** Nonproliferative Diabetic Retinopathy
- ❑ **SEVERE** Nonproliferative Diabetic Retinopathy
- ❑ Diabetic Macular Edema
- ❑ Clinical Significant Macular Edema
- ❑ Micro-Aneurysms
- ❑ Cystoid Macular Edema
- ❑ Retinal Edema
- ❑ Branch Retinal Vein Occlusion
- ❑ Central Retinal Vein Occlusion
- ❑ Wet Macular Degeneration
- ❑ Choroidal Neovascular Membrane
- ❑ Retinal Detachment
- ❑ Retinal Tear / Hole
- ❑ Lattice Degeneration
- ❑ Vitreous Hemorrhage
- ❑ Neovascular Glaucoma
- ❑ Neovascularization of the Iris
- ❑ Neovascularization of the Optic Nerve
- ❑ Neovascularization Elsewhere
- ❑ Central Serous Retinopathy
- ❑ Retinopathy of Prematurity
- ❑ Retinal Tumor
- ❑ Retinal Lesion
- ❑ Other_____

I (we) understand that my physician may discover other or different conditions that may require an additional laser treatment than initially planned.
I (we) authorize my physician to perform the necessary laser treatment that is advisable in their best professional judgment.
I (we) understand that no warranty or guarantee has been made to me as to result or cure.
I (we) understand that continuing without treatment can cause my condition worsen
I (we) understand that the following are risks and hazards can occur during and after receiving a laser treatment

Infection
Bleeding
Partial or total loss of vision
Complications requiring additional treatment and/or surgery
Increased intraocular pressure
Persistent pain

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) have been given an opportunity to ask questions about the procedure and my condition, along with alternative forms of treatment and non-treatment.
I (we) understand that in the event of a complication from the laser, it may be necessary to travel to the Abilene office for emergency treatment
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 / or Legally Responsible Person Signature

_____
Witness Signature

Date:_____ Time:_____