**McLaren Flint**
FLINT, MICHIGAN 48532

**INFORMED CONSENT FOR CATARACT SURGERY**

1. I have been told by my physician, that my present condition or conditions may effectively be treated by the following procedure(s)

☐ **Left Eye** ☐ **Right Eye removal of cataract with insertion of intraocular lens prosthesis**

I hereby authorize my physician and the associates and assistants selected by him to perform the described procedure(s).

2. I have been told that during the course of the described procedure(s), unforeseen conditions may be discovered that necessitate an extension of the original procedure(s) or different procedures(s) than those described in Paragraph 1. I authorize the above physician, his associates and assistants, to perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted in this Paragraph 2 shall extend to treating all conditions that require treatment and are not known to the physician at the time the original procedure(s) is commenced.

3. I am aware that McLaren Flint is a resident teaching facility and that physician residents will be involved with my care under the supervision of my physician. I consent to their involvement and participation in my treatment planning and care.

4. I understand that such procedure(s) may involve transfusion of blood or blood cell products. I have been made aware that, despite routine screening procedures, use of blood and blood cell products always carries some risk of transmissible disease, including hepatitis virus, or other blood-borne agents. I give authorization to administer to me during the procedure(s): ( ) regular blood or blood products from the Blood Bank; ( ) autologous blood only (blood I have given; ( ) designated (directed) donations only; ( ) no blood products. In the absence of a sufficient quantity of blood I have given, I understand regular blood or blood products from the Blood Bank will be used.

5. I agree to the use of anesthesia and/ or sedation as deemed appropriate by the anesthesiologist or his/her designee. It has been explained to me that all forms of anesthesia involve some risks and although rare, unexpected severe complications may occur including but not limited to mouth or throat pain, injury to mouth or teeth, infection, injury to blood vessels, headache, backache and others. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. I consent to the anesthesia service discussed with the anesthesia provider. I also consent to an alternative type of anesthesia if necessary as deemed appropriate by my anesthesia provider.

6. I hereby authorize McLaren Flint to retain, preserve, and use for scientific or teaching purposes or dispose of, at its discretion, any specimen or tissue taken from my body.

7. I acknowledge that full discussion has taken place between my physician and me prior to the procedure(s) herein authorized, that the advantages and disadvantages of such procedure(s) including the risk of infection, have been explained to me, and that alternative methods of treatment have been discussed with me. I have been made aware of certain risk(s) and consequences that are associated with the procedure(s) described in Paragraph 1 and understand that submitting to the procedure(s) may endanger my life or future health.

8. I am aware that the practice of medicine and of surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

_____ Date/Time _____
(Signature of Patient)

(If patient is unable to sign or is a minor, complete the following:)
Patient is unable to sign because :

_____

_____ _____
(Witness) Authorized Patient Representative

I, herby attest to providing information regarding the patient's risks, including risk of infection, benefits, as well as alternative methods of treatment available to aid the patient and family in the decision process regarding this procedure.

_____ Date/Time _____
Signature of Physician

_____ Date/Time_____
Anesthesia Provider Signature

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PT.

MR.#/P.M.

DR.