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# Informed PRK Consent

## For the Correction of Nearsightedness, Farsightedness, and/or Astigmatism with Photorefractive Keratectomy (PRK)

Patient _____
First name

_____
Last name

D.O.B _____ SS# _____

Surgical Eye  ☐ Right  ☐ Left

### Introduction and Alternatives

This information and all other information provided by this office must be reviewed so you can make an informed decision regarding Photorefractive Keratectomy (PRK) surgery to reduce or eliminate your nearsightedness. Only you and your doctor can determine if you should have PRK surgery based upon your own visual needs and medical considerations. Any questions you have regarding PRK or other alternative therapies for your case should be directed to your doctor.

The alternatives to PRK include eyeglasses, contact lenses, or a refractive surgery procedure such as radial keratotomy. Each of these alternatives to PRK has been explained to me.

**In giving my permission for PRK surgery, I declare that I understand the following information:**

The goal of PRK with the excimer laser is to reduce or eliminate the dependence upon or need for contact lenses and/or eyeglasses; however, I understand that as with all forms of treatment, the results in my case cannot be guaranteed. For example:

1. There is no guarantee that I will completely eliminate my reliance on eyeglasses and/or contact lenses. It is possible that the treatment could result in undercorrection, where some degree of nearsightedness may remain, requiring the use of glasses or contact lenses.

I have read and understand this page. Patient initials _____

2. The treatment may also result in overcorrection, causing hyperopia (farsightedness) which may or may not require the use of glasses or contact lenses.

3. If I currently need reading glasses, I will likely still need reading glasses after this treatment. It is possible that dependence on reading glasses may increase or that reading glasses may be required at an earlier age if I have PRK surgery.
4. The treatment may also result in a change in my astigmatism that could require the use of glasses and/or contact lenses.

5. Further treatment may be necessary including a variety of eyedrops, the wearing of eyeglasses or contact lenses (hard or soft), or additional PRK surgery.

6. My best vision even with glasses or contacts may become worse.

7. There may be a difference in spectacle correction between eyes, making the wearing of glasses difficult or impossible. Fitting and wearing contact lenses may be more difficult.

## Possible Side-Effects and Complications

I have been informed, and I understand, that certain complications and side effects have been reported in the post-treatment period by patients who have had PRK, including the following:

**Possible short-term effects of PRK surgery:**

The following have been reported in the short-term post-treatment period and are associated with the normal post-treatment healing process: mild discomfort or pain (first 24 to 48 hours), corneal swelling, double vision, feeling something is in the eye, ghost images, light sensitivity, and tearing.

**Possible long-term complications of PRK surgery:**

1. Haze: Loss of perfect clarity of the cornea, usually not affecting vision, which usually resolves over time.

2. Glare: Sensation produced by bright lights that is greater than normal and can cause discomfort and annoyance.

3. Halo: Hazy rings surrounding bright lights may be seen, particularly at night.

I have read and understand this page. Patient initials _____

4. Loss of Best Vision: A decrease in my best vision even with glasses or contacts.

5. IOP Elevation: An increase in the inner eye pressure due to post-treatment medications, which is usually resolved by drug therapy or discontinuation of post-treatment medications.

The following complications have been reported infrequently by those who have had PRK surgery: itching, dryness of the eye, or foreign body feeling in the eye; double or ghost images; patient discomfort; inflammation of the cornea or iris; persistent corneal surface defect; persistent corneal scarring severe enough to affect vision; ulceration/infection; irregular astigmatism (warped corneal surface which causes distorted images); cataract; drooping of the eyelid; and a slight increase of possible infection due to use of a bandage contact lens in the immediate post-operative period.

## Patient's Statement of Acceptance and Understanding

I understand there is a remote chance of partial or complete loss of vision in the eye that has had PRK surgery.

I understand that it is not possible to state every complication that may occur as a result of PRK surgery. I also understand that complications or a poor outcome may manifest weeks, months, or even years after PRK surgery.

I understand this is an elective procedure and that PRK surgery is not reversible.

**For women only:** I am not pregnant or nursing. I understand that pregnancy could adversely affect my treatment result.

**For presbyopic patients:** (those requiring a separate prescription for reading): the option of monovision has been discussed with my ophthalmologist.

I have read and understand the information that has been provided to me. I have spoken with my physician, who has explained PRK, its risks and alternatives, and answered my questions about PRK surgery. I therefore consent to having PRK surgery.

I have read and understand this page. Patient initials _____

My personal reasons for choosing to have PRK surgery are as follows:

_____

_____

_____

_____

_____

The details of the procedure known as Photorefractive Keratectomy (PRK) have been presented to me in detail in this document and explained to me by my ophthalmologist. Dr. Benjamin has answered all my questions to my satisfaction, I therefore consent to have PRK surgery on:

_____
Date of Surgery

I give permission, for my ophthalmologist to record on video or photographic equipment my procedure, for purposes of education, research, or training of other health care professionals, I also give my permission for my ophthalmologist to use data about my procedure and subsequent treatment to further understand Photorefractive Keratectomy. I understand that my name will remain confidential, unless I give subsequent written permission for it to be disclosed outside my ophthalmologist's office or the center where my PRK procedure will be performed.

Surgical Eye  ☐ Right  ☐ Left

_____ _____
Patient's Signature Date

_____
Patient's Name (please print)

_____ _____
Witness' Signature Date

_____
Witness' Name (please print)

I have read and understand this page. Patient initials _____



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