



**CONSENT FORM
FOR
CORNEAL GRAFT**

Med Rec. No.....

Surname:.....

Forename:

DOB:.....

AFFIX LABEL HERE

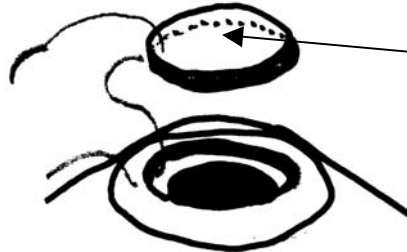
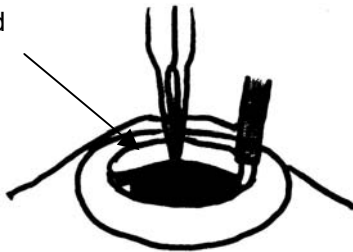
PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*)
haveand that a **corneal graft** on
theside is proposed:

This means replacing the damaged surface of the eye (cornea) with a graft from a human donor.

Usually under general anaesthetic, the central area of the damaged cornea is cut away and replaced by the clear, donor graft. This has previously been treated with antibiotic. The graft is held in position with very fine stitches, which have to remain until the cornea has healed (which may take up to a year or longer). The eye is covered with a pad and protective shield for a short while after the operation.

Damaged cornea being cut away



Graft being sewn into place

RISKS

These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your ophthalmic surgeon if you have any general or specific concerns.

I understand there are risks associated with any **anaesthetic** (see separate *Anaesthetic Consent Form*). I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand the procedure has the following **specific risks and limitations**:

- My eyesight will be blurred immediately after the operation, and although this will clear, I may still notice temporary changes in clarity for some months as healing continues.
- My final visual recovery may continue for 12-18 months, at which time the corneal stitches are removed.
- My eye is likely to water and be sensitive to light for a short while after the operation.
- The shape of the donor cornea may be different from my own and I may need spectacles or a contact lens to improve my vision, after the graft has healed.
- My vision should be improved by the procedure, but my general health and the condition of my eye may also affect the final outcome.
- I may have some bleeding in my eye, which may mean I need to return to the operating theatre.
- I may develop an infection in my eye, which may require antibiotics
- I will be given eye drops to use for some months after the operation to help prevent infection and rejection and I understand I must use these exactly as directed.
- There is a small chance I may develop a cloudy lens (cataract), increased pressure inside the eye (glaucoma) or the retina (the part of the eye that senses light) may become detached, after the surgery. Any of these may damage my vision if not treated.
- There is always the chance my body may reject the graft, even years after the operation. I understand that I must report any pain, reduced sight or redness in the eye within 24 hours to an eye department
- There is an extremely small risk (1:17000 cases) that my opposite eye to the one having surgery may become inflamed, especially if complications occur after the operation. This is called sympathetic ophthalmia and can affect any operation inside the eye. Although this can be treated, in some cases, my eyesight may be lost.

RISKS CONTINUED OVERLEAF →

[HOSPITAL]

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RISKS CONTINUED

- Eye surgery for any condition always carries a small risk that vision may be worse or totally lost after the operation. Occasionally my eye itself may be lost. In some cases, complications may occur weeks, months or even years after the operation.

INDIVIDUAL RISKS

I understand the following are possible significant **risks and complications specific to my individual circumstances**, that I have considered in deciding to have this operation:

.....
.....

DECLARATION BY PATIENT

- I acknowledge the doctors from the ophthalmic team have informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the surgical team any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my surgeon during this operation.
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I have received no guarantee the operation will be successful
- I understand that a doctor other than the specialist surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If a needlestick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.
- I understand these operations may be recorded for student training purposes. However, any recordings used for teaching are only used after all identifying material has been removed.

Signature of patient

.....

Date

.....

If the patient is an adult and unable to give consent, a proxy form must be completed and attached

DECLARATION BY DOCTOR

- I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature

.....

Doctor's name

.....

Date

.....

(please print)

INTERPRETER'S DECLARATION - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's signature

.....

Date

.....

Interpreter's name

.....

(please print)