



**CONSENT FORM
FOR
SURGERY FOR RETINAL
DETACHMENT**

Med Rec. No.....

Surname:.....

Forename:

DOB:.....

AFFIX LABEL HERE

PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*)
have a **retinal detachment** in my.....eye and that.....is proposed:

Retinal detachment usually means one or more tears (holes) have developed in the layer of nerve cells that sense light. Fluid from inside the eye may leak behind the retina, lifting it away from the deeper tissues and damaging vision.

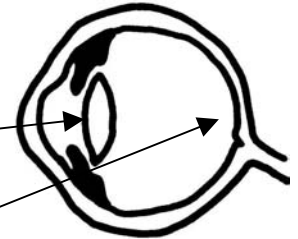
The surgeon aims to seal the tear and prevent the retina lifting away from the back of the eye again. Simple tears can be sealed using laser photocoagulation, but detachments often require a means of pressing the retina and deeper layers together until healing can occur.

Techniques depend on the individual case, so your surgical team will discuss the intended procedure with you.

NORMAL EYE

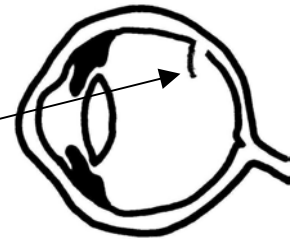
lens

retina



PROBLEM EYE

retinal detachment



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**:

- Although most retinal detachments can be treated, a small proportion (~5%) may not be repairable.
- In some cases, more than one operation may be required.
- It may take up to 18 months before the final outcome of the surgery is known. Although many cases achieve a good result, this depends on several factors including how long the detachment had been present. In a few, the underlying condition cannot be treated and blindness cannot be prevented. It may not be possible to predict before the operation which cases will do well.
- There is a chance I may develop further retinal detachments in future in the same eye or in the opposite eye.
- There is a small chance I may develop a cloudy lens (cataract), increased pressure inside the eye (glaucoma), infection or bleeding inside the eye after the surgery. Any of these may require further treatment and any may ultimately result in blindness.
- There is an extremely small risk (1:17000 cases) that the 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, eyesight may be lost.

I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

RISKS CONTINUED OVERLEAF →

[HOSPITAL]

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RISKS CONTINUED

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 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 understand that a doctor other than the specialist surgeon may perform the procedure.
- I have received no guarantee the operation will be successful.
- 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.

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 name _____
(please print)

Interpreter's signature _____