This form is intended as a sample. It does not constitute the standard of care nor does it provide legal advice. It contains the information OMIC recommends the surgeon personally discuss with the patient.

**How to use this sample**

* Please modify it to fit your practice.
* **Delete this instruction box.**
* Add your letterhead to the first page of the consent form.
* Change font size if necessary.

**After the patient signs the form**

* Give the patient a copy of the signed form.
* Send a copy to the hospital or surgery center as verification that you have obtained informed consent.
* Keep the original in the patient’s medical record.

**Version** 02/12/2020

 **[Your Letterhead]**

**Informed Consent for Anterior Chamber Paracentesis**

You have Glaucoma, and your doctor, [Name, MD/DO], is recommending Anterior Chamber Paracentesis.

**What is Glaucoma?**

You have glaucoma. Glaucoma is a disease defined by optic nerve damage. The optic nerve connects the eye to the brain. The damage to the optic nerve in glaucoma is thought to be caused by fluid imbalance or pressure in the eye. Glaucoma slowly gets worse over time and cannot be reversed. If it is not treated, it causes a painless loss of eyesight. In some cases, it can lead to blindness.

**About Anterior Chamber Paracentesis**

You have high eye pressure. High eye pressure can damage the eye and cause vision loss. If the eye pressure is severely high, the vision loss can occur rapidly and be permanent. Your ophthalmologist (eye surgeon) recommends an anterior chamber paracentesis.

The ophthalmologist creates an opening for fluid to leave the eye. The opening can be a new one, or through an incision from a prior surgery.

[Include a statement:] This is an elective procedure. You do not have to have Anterior Chamber Paracentesis.

**Benefits**

**How will Anterior Chamber Paracentesis treat my vision and/or condition [How can this medication help]?**

The goal of a paracentesis is to adjust your eye pressure and save the vision you have now. It may not bring back vision you have already lost.

* [State the limitations of the surgery, e.g.:] This surgery will not correct [ ].
* [State the need for follow-up after surgery, e.g.:] Careful follow-up is required after surgery. After your eye heals, you will still need regular eye exams to monitor your [condition] and to watch for other eye problems.
* [State any minor problems that could occur following the procedure.]

**Risks**

**What are the main risks of Anterior Chamber Paracentesis?**

There is no guarantee that the Anterior Chamber Paracentesis will improve your condition. Sometimes it doesn’t work. In addition, Anterior Chamber Paracentesis is risky. Sometimes it can make the problem worse, cause an injury, or create a new problem; if it does, this is called a complication. Complications can happen right away or not until days, weeks, months, or years later. You may need more treatment or surgery to treat the complications.

It is impossible to list all risks and complications that may occur. The main risks and complications of Anterior Chamber Paracentesis are:

* Failure to control eye pressure, with the need for eye drops, laser treatment, or another operation
* Abnormal collection of fluid in the eye, with the need for another surgery
* Worse or lost vision
* Pressure that is too low
* Damage to the eyeball or structures inside the eye such as the iris or the lens
* Infection
* Bleeding in the eye
* Inflammation
* Pain, irritation, or discomfort in the eye or surrounding tissues that may last
* Problems during surgery that need immediate treatment. Your ophthalmologist may need to do more surgery right away or change your surgery to treat this new problem.
* Other risks. There is no guarantee that the procedure will improve your vision. It might make your vision worse, cause blindness, or even the loss of an eye. These problems can appear weeks, months, or even years after surgery.

**How will complications during surgery be handled?**

If a complication happens during surgery, your surgeon may need to perform another surgery right away to treat it. Your surgeon may discover a new condition or problem for the first time during the surgery. The surgeon may need to change the plan for surgery to treat this problem or condition right away.

**Instructions**

**Tell your ophthalmologist right away if you notice any other problems after Anterior Chamber Paracentesis , such as:**

* [Example:] Eye pain, blurry or decreased vision, extra sensitivity to light, eye redness, and pus or other discharge coming from the eye.
* [Example:] New or large floaters that do not go away.
* [Example:] Flashing lights or decreased side vision with the floaters.

**You must follow these instructions:**

You can help prevent or reduce the above problems by doing the following:

* Call your ophthalmologist right away if you notice any of these problems.
* Keep all appointments with your ophthalmologist.

**Alternatives**

**What alternatives are there for my condition (choices and options)?**

Anterior Chamber Paracentesis is not the only option. Your other treatment choices may include:

* [Provide other treatment options, both medical and surgical.]
* No treatment. [Describe consequences of refusing the surgery or treatment, e.g.:] “If you decide not to have surgery, your eye problems can quickly get worse. You could have more vision loss or even blindness.”

**Anesthesia**

**What type of anesthesia is used? What are its main risks?**

An anterior chamber paracentesis is performed under topical anesthesia, which means that eye drops are used to numb the eye. You must be able to cooperate with the ophthalmologist to make sure you do not move your eye during the procedure. Risks of topical anesthesia include injury to the eye by movement during surgery, drooping of the eyelid, and increased sensation during the procedure.

**Who will perform my surgery?**

Your surgery will be performed by your surgeon. [Describe] may be present at your surgery and may participate in the surgery under the direct supervision of your surgeon for all critical portions of the surgery. Some aspects of your pre- and post-operative care may be provided by your surgeon; other [Describe]; or your primary eye care provider.

**Consent to Treatment**

**By signing below, you** **agree and consent to the following:**

* Your ophthalmologist has discussed the information in this consent form with you and has answered your questions to your satisfaction.
* You understand the risks, benefits, and alternatives of Anterior Chamber Paracentesis, as well as the consequences of refusing treatment, and you accept the risks.
* You understand that it is impossible for the ophthalmologist to inform you of every possible complication that may occur.
* You understand that, during the procedure, unforeseen complications or conditions may occur or be found that require additional or alternative procedures, and you authorize such procedures to be performed.
* You understand the signs and symptoms to watch for after Anterior Chamber Paracentesis and agree to report them to your ophthalmologist immediately.
* [For a series of treatments:] You consent to keep having [ ] unless you tell your ophthalmologist that you no longer want the treatment, or your eye problems or other relevant health issues change so much that there are new risks and benefits to discuss with the ophthalmologist.
* [If Betadine® is used:] Your ophthalmologist has informed you that Betadine® is a proven effective method for surface cleaning of the eye and surrounding areas, which reduces the risk of infection. You understand and acknowledge that if you choose to refuse the use of Betadine®, it may increase the risk of infection with this procedure.
* You acknowledge that no guarantees our promises have been made to you about the results of any procedure or treatment.
* You have been offered a copy of this document.

I authorize my ophthalmologist to proceed with Anterior Chamber Paracentesis in/on my:

**\_\_Left** eye \_\_**Right** eye \_\_**Both** eyes

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature (or person authorized to sign for patient) Date

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Printed Name