

LASER CONSENT FORM

DATE:

NAME:

DOCTOR:

PROCEDURE: **Focal Laser- Macular Pan-Retinal Photocoagulation**

DIAGNOSIS: _____

EYE: **RIGHT / LEFT**

1. I hereby consent to the above Laser treatment of my RIGHT / LEFT eye to be performed by Dr. _____.
2. Dr. _____ has explained the nature and purpose of this procedure, as well as risks, benefits, and options involved.
3. I consent to the administration of anesthesia, if required, and to the use of such anesthetics and techniques as may be deemed advisable. I understand that the anesthetic will be administered by a person qualified in the administration of the appropriate anesthetic.
4. No guarantee has been given as to the results that may be obtained.
5. I acknowledge that I have read and understand the above.

WITNESS

SIGNATURE OF PATIENT

DATE

If patient is unable to consent:

SIGNATURE OF PERSON AUTHORIZED
TO CONSENT FOR PATIENT

RELATIONSHIP TO PATIENT

DATE