LASER CONSENT FORM

DATE:

NAME:

DOCTOR:

PROCEDURE: **Peripheral Pan-Retinal Photocoagulation (P-PRP)**

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