

## **LASER CONSENT FORM**

**DATE:**

**NAME:**

**DOCTOR:**

**PROCEDURE:**     **YAG Laser Capsulotomy**

**DIAGNOSIS:**     **Secondary Membrane (366.53)**

**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