**TEXAS OPHTHALMIC PLASTIC, RECONSTRUCTIVE AND**

# ORBITAL SURGERY ASSOCIATES

**GRANT GILLILAND, M.D. P.A. IVAN VRCEK, M.D. P.A. JOHN HARRINGTON, M.D. P.A.**

## INFORMED CONSENT

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I voluntarily request Dr. **Harrington / Gilliland / Vrcek** as my physician, and such associates, technical assistants, resident physicians and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

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I understand the following surgical, medical and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures:

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I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

Furthermore, I authorize Dr. Harrington / Gilliland to utilize the treatment methods, materials and equipment they deem most appropriate with the following exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_, I understand that with eyelid and orbital surgery cosmetic results are difficult to predict and impossible to guarantee. It has been explained to me that with eyelid surgery there is an at least 15% rate of reoperation due to many factors including over and under correction. It has been thoroughly explained to me that follow up surgery may be required (possibly at patient expense). Removal of stents, tubes, prosthesis etc. whether done in the office or in the operating room will be charged to the patient and/or the patient's insurance company.

I consent to the administration of such anesthetics as may be considered necessary or advisable by my physician, the Anesthesiologist or the Certified Registered Nurse Anesthetist under the direction of my physician.

I do / do not consent to the use of blood and blood products as deemed necessary.

I consent to the disposal by hospital authorities and my physician of any tissues or body parts which may be removed.

I consent to be photographed, audio/videotaped, recorded, televised or interviewed for medical, scientific or educational purposes. Filming or photographing of an operation or procedure may include appropriate portions of my body. My identity may be revealed by the pictures but not by descriptive texts accompanying them – these photographs/video’s and other media may be used for educational or marketing purposes including placement on our website.

I understand that no warranty or guarantee has been made to me as a result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I understand and give consent to the use of electrical and other methods of cauterization and the use of lasers during surgery. These modalities may have risks including but not limited to burns and thermal damage. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. The risks and hazards with this particular procedure have been explained to me by my physician and include but are not limited to the following:

BLEEDING

INFECTION

SCARRING

NERVE DAMAGE

NUMBNESS

NEED FOR ADDITIONAL SURGERY

OVER AND UNDER CORRECTION

EYELID DEFORMITY

DOUBLE VISION

PARTIAL OR TOTAL LOSS OF VISION

DRY EYE

INABILITY TO CLOSE THE EYE

HAIR LOSS

BRAIN INFECTION

BRAIN FLUID LEAK (CSF)

INJURY TO THE EYE

RECURRENCE OF THE DISEASE

ALTERED PIGMENTATION

POOR COSMETIC RESULT

AND OTHER RISKS AS DISCUSSED BY MY PHYSICIAN

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I understand that anesthesia involves additional risks and hazards, but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I realize the anesthesia may have to be changed possibly without explanation to me. I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage and even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved and I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filed in, and that I understand its contents.

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SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON (STATE RELATIONSHIP) DATE TIME

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WITNESS TO SIGNATURE SIGNATURE OF TRANSLATOR ( IF USED )

BEFORE THIS SURGERY, I INFORMED THE PATIENT AND/OR THE FAMILY MEMBERS OF

THE RISKS, BENEFITS AND ALTERNATIVES TO THIS SURGICAL PROCEDURE.

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SIGNATURE OF SURGEON