Patient Details / Label

Surname _____

First Names _____

Date of Birth _____

NHS / Hospital Number _____

NHS England
NHS Improvement

Special requirements e.g. communication: _____

For adult patients with mental capacity to give valid consent to:

Cataract Removal and Lens Implant

(Phacoemulsification and Intraocular Lens)

Right / Left / Both (Same day / Different day)

Anaesthetic: [ ] Anaesthetic drops [ ] Injection [ ] Oral sedation
[ ] Intravenous sedation [ ] General Anaesthetic

Patient Information & Advice:

RNIB: www.rnib.org.uk/eye-health/your-guide-cataracts/when-should-i-have-cataracts-surgery

NHS.UK: www.nhs.uk/conditions/cataract-surgery/

Hospital eye clinic leaflet or Cataract booklet – please ask for one if not provided

COVID-19: In the majority, COVID-19 causes a mild self-limiting illness, but symptoms may be highly variable amongst individuals, and it is important you understand the specific risk profile to yourself. There is no guarantee of zero risk of COVID-19 transmission.

For more information: www.gov.uk/coronavirus

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BENEFITS: To improve vision (most will still need glasses)

Other benefits:_____

RISKS:

Common: up to 1 in 20

- High eye pressure, inflammation, or discomfort of the eye that may require further clinic visits or temporary treatment with drops

Uncommon: up to 2 in 100

- Rupture of the membrane or capsule holding the cataract, requiring further follow-up, treatment, or possible further surgery
- Retinal problems (problems with the photographic film of the eye), such as retinal swelling or detachment
- Unexpected prescription after surgery, needing stronger glasses or contact lenses, or even further corrective surgery
- Permanent mild loss of vision that cannot be improved with glasses

Rare: up to 1 in 1000

- Infection or bleeding inside eye
- Glaucoma (high pressure inside eye) requiring long term treatment
- Swelling of the cornea (clear window of the eye) requiring long term treatment or surgery
- Permanent severe loss of vision that cannot be improved with glasses or further surgery
- Other e.g. pupil shape change, double vision, droopy eyelid

Very rare: up to 1 in 10,000

- Inflammation which could affect the vision in both eyes
- Dislocation or clouding of the lens implant requiring further surgery to exchange the lens

Specific Or Material Risks For This Patient:

_____

_____

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Lens wear and tear: About 10% of people, in their lifetime, may develop clouding of a naturally occurring membrane behind the lens implant, that may need a minor laser procedure in clinic to improve the vision.

Health Professional: I assess that this patient has capacity to give valid consent. I have discussed what the procedure is likely to involve, the benefits and risks of this, and of any available alternative treatments / no treatment, and any particular concerns of this patient. The patient has been given the opportunity to ask questions. They have been provided with a **Cataract surgery leaflet / booklet** [ ]

Signed_____ Date _____

Name (PRINT) _____ Job title _____

Patient: Please read this form carefully, it describes the benefits and risks of the treatment. **You will be given a copy of this form** to keep and a copy of an information leaflet about cataract surgery. **Please ask for a leaflet if not offered one.** If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that any procedure in addition to that described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my general or eye health.

Patient's signature_____ Date_____

Name (PRINT) _____

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Interpreter (where appropriate): I have interpreted the information above and the discussions between the patient and the professional to the best of my ability and in a way in which I believe s/he can understand.

Signed_____ Date_____

Name (PRINT)_____

Witness (if the patient is unable to sign but has indicated consent):

Signed_____ Date_____

Name (PRINT) _____

Confirmation of Consent RIGHT EYE

(Nurse / Doctor consenter to complete on day of surgery)

Signed_____ Date _____

Name (PRINT) _____ Job title _____

Confirmation of Consent LEFT EYE

(Nurse / Doctor consenter to complete on day of surgery)

Signed_____ Date _____

Name (PRINT) _____ Job title _____