VISION REJUVENATION™ VICTORIA

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AUTHORIZATION AND REQUEST FOR REFRACTIVE LENS EXCHANGE WITH VISION ENHANCEMENT PROCEDURES

DO NOT SIGN THIS FORM UNTIL
YOU HAVE READ AND FULLY UNDERSTAND IT.

PLEASE TAKE AS MUCH TIME AS YOU WISH,
AND ASK ANY QUESTIONS YOU MAY HAVE AT ANY TIME.

INTRODUCTION

This information is provided to improve your understanding of medical limitations of possible risks and complications in undergoing **Refractive Lens Exchange**. You are encouraged to ask questions during your assessment and consultation with your physician if anything is unclear. Your decision about whether or not to have this surgery at this time should be based on the information presented in the patient information given to you, as well as on the conversation with your physician and his staff and on an understanding of potential risks and complications described on this form.

BY SIGNING THIS FORM I ACKNOWLEDGE THAT I UNDERSTAND THE FOLLOWING:

1. Refractive Lens Exchange and associated Vision Enhancement Procedures are considered major operations for the eye. The chance of incurring a significant complication is less than one percent. Medications, treatments, other procedures and time can correct many of the possible serious complications.

2. The eye to be operated on has imperfect ability to focus due to one or more of the following: **Hyperopia** (farsightedness), **Myopia** (nearsightedness), **Astigmatism**, and **Spherical Aberration of Aging** (progressive loss of contrast and night vision in almost all people over forty years of age).

3. The objective of the Refractive Lens Exchange with Vision Enhancement Procedures is to reduce or eliminate hyperopia, myopia and astigmatism as well as to improve contrast and night vision where possible. Slight myopia is usually created in one or both eyes to permit a greater range of spectacle free vision.
   Multifocal or *Accommodating* intraocular lens implants are necessary for achieving a more complete range of spectacle free vision. Provided that I am a suitable candidate for one of these lenses and can afford the increased cost, I may choose this option.

   Our Refractive Lens Exchange program also includes **Vision Enhancement Procedures** required at surgery or in the postoperative period to obtain optimal vision. This might include:
   - Astigmatic Keratotomy [graded incisions in the outer cornea to alter its shape]

- Secondary low-power lens implant insertion [inserted over the primary lens]
- Intraocular lens exchange [changing lens implant to optimize focus]
- Conductive Keratoplasty [radio-frequency energy applied to outer cornea to alter its shape]
- PRK or LASIK [laser shaping procedures of the cornea]

4. It is **never** necessary to have Refractive Lens Exchange. **The procedures involved are purely elective**.

5. Alternatives to Refractive Lens Exchange include:

   (a) Eyeglasses – the traditional means of correcting hyperopia, myopia and/or astigmatism. They do not improve contrast /night vision.
   (b) Contact lenses -- They do not improve contrast /night vision.
   (c) Other surgical procedures, such as Refractive Excimer laser surgery, etc. These may worsen contrast and night vision and do not treat cataract vision loss.

6. While most people have benefited from and have been satisfied with the outcome of this surgery:
   (a) Some have not been completely satisfied by the quality of their vision and degree of spectacle freedom.
   (b) A few have experienced persistent complications after having had Refractive Lens Exchange

7. This surgery is a compromise, and having Refractive Lens Exchange does not necessarily mean total freedom from contact lenses or glasses. The aim of this surgery is to achieve good **functional** vision, **NOT perfect** vision. Spectacles or contact lenses may be required to attain perfect vision at some or all distances.

Patient Initials _____

RISKS OF REFRACTIVE LENS EXCHANGE WITH VISION ENHANCEMENT PROCEDURES

Potential complications may result in distorted or impaired vision and/or discomfort. These are all quite rare and most can be successfully treated with medications, other procedures or the passage of time.

1. ***Vision threatening complications:*** Some rare complications may have the potential to cause permanent loss of vision and even loss of an eye. Some possible complications include: opacification of posterior capsule (this is treatable with YAG laser), hemorrhage, retinal detachment, glaucoma, uveitis, iritis (inflammation), iris atrophy, loss of corneal clarity, change in pupil size or shape, dislocation of the lens implant, double vision (less likely with topical anaesthesia), loss of vitreous (gel in eye), flat anterior chamber, loss of best corrected vision, fluid circulation problems, internal adhesions, wound leak, permanent droopiness of the eyelid (less likely with topical anaesthesia), inflammation/swelling of the retina, infection (internal or external) that cannot be controlled by antibiotics or other means.

The most important complication of all, a significant loss of best corrected vision, occurs only rarely [our incidence is about one in 1000, much less for patients under 70 years of age]

2. ***Non-vision threatening complications:*** These all usually improve with or without treatment over time.

(c) Increased dryness and irritation of the eye
(d) Reflections or slight distortions from intraocular lens implant
(e) An increase or alteration in the shape, size and number of floaters

SPECIAL CONSIDERATIONS REGARDING SURGERY

1. I have received no guarantee as to the success of the surgery in my particular case.
2. I agree to arrange for somebody to accompany me and drive me home after my procedure and I agree to refrain from driving myself until I am confident with my vision both day and night.
3. As in all surgery, there is the possibility of other complications due to anaesthesia, drug reaction, or other factors that involve other parts of the body. These complications cannot be fully described in this document.

In giving permission for Refractive Lens Exchange with Vision Enhancement Procedures, I declare that I understand the information presented, have read the above, and have had the opportunity to discuss all aspects of the procedure with my doctor and his/her assistants to my satisfaction.

I HEREBY REQUEST REFRACTIVE LENS EXCHANGE WITH VISION ENHANCEMENT PROCEDURES TO BE PERFORMED BY DR. L.A. BRIERLEY ON MY RIGHT/LEFT EYE (circle RIGHT &/OR LEFT)

PERSON GIVING CONSENT (Print name): _____

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

SURGEON'S SIGNATURE: _____ DATE: _____