

CATARACT SURGERY

INSTRUCTIONS

This is an informed consent document that has been prepared to assist your ophthalmologist inform you concerning cataract surgery, its risks, and alternative treatment.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your ophthalmologist and agreed upon by you

A.Regarding my disease,described as cataract in medical literature

I have been informed on the following:

- My medical conditionit,its possible reasons and naturel course,
- About the recommended intervention/procedure/surgery:

a.the surgeon,location,method and estimated duration

b.expected benefits,

c.likelihood of success,

d.all risks including death,possible complications and other problems,

e.risks that may be encountered if I reject to have the intervention/procedure/surgery performed,

- Significant characteristics of the drugs to be used during or after the

a.recommended intervention/procedure/surgery,

b.blood,blood product transfusions that might be required and possible risks thereof,

- Possible problems related to the postoperative recovery period and significant matters to be considered,
- Other diagnosis and treatment options to be considered and their benefits,risks and possible effects on my health,
- Lifestyle recommendations that are critical to my health,
- How to contact and get Access to medical assistance when required.I have asked and got informed about the matters that I couldn't understand.

B. I know that no specific guarantees can be given to me about the results.

C. If any emergency thatcan risk my life occurs or any risk emerges that could lead to an emergency or an organ/functionloss during the planned intervention/procedure/surgery and when I am unconscious; I hereby authorize my physician and other health personel to perform interventions,procedures or surgeries to prevent such risks.

D. I consent to performance of blood and blood product transfusion when needed during my treatment.

E. If required by theintervention,procedure or surgery, I consent to intracorporeal and extracorporeal photographing, other imaging processes,and asrching thereof as long as privacy is maintained.

F. I have been informed about theaverage cost of theintervention,procedure or surgery.I understand that this costmight change if any additional medical intervention/procedure/surgery is required.

G. I voluntarily consent and give may authorization to the performance of below-stated inrventions-procedures or surgeries as deemed necessary.



**KATARAKT AMELİYATI
İNGİLİZCE
BİLGİLENDİRİLMİŞ ONAM FORMU**

Dokuman No	YÖN.RB.161-01
Yayın Tarihi	16.01.2010
Rev.No	02
Rev.Tarihi	27.10.2016
Sayfa no	2/2

Patient's consent form:

I read the information above and was informed by my ophthalmologist, who has his/her signature below.

I am informed about the aim of the operation and possible risks and complications. I agree to have the surgery done to my right (.....) left (.....) eye.

The estimated duration of the process: 30 - 60 minutes.

Important properties of the medicines that may be used: I have been informed about the important features (what it is used for, how it is used, benefits, side effects) of the medicines that will be used during my treatment/approach in the hospital.

Lifestyle recommendations that are critical to the patient's health: I have been informed about postoperative lifestyle advice that I am supposed to do (Diet, bathing, drug use, movements that have to be done or not done).

How to access medical assistance on the same subject in case of need: I have been informed about how to access medical assistance on the same subject such as own doctor, a different doctor, clinic that treated and contacting 112 in emergency.

Phone numbers to contact us: Hospital Phone: +902122746925 – 4442593

You can directly contact your doctor to get detailed information about the treatment.

Please declare with your own handwriting that you understand what you read and understand about your illness/surgery, treatment duration, surgery, possible side effect that may occur and all possible risks:

.....
.....

Date:...../...../..... Time:.....

IF THE PATIENT'S CONSCIOUS	IF THE PATIENT'S UNCONSCIOUS AND ACCOMPANIED BY HIS/HER LEGAL REPRESENTATIVE
Patient's Name Surname : Address : Phone : Signature :	legal representatives* or guardians Name Surname : Address : Phone : Signature :
Doctor Name Surname:..... Signature:	Doctor Name Surname:..... Signature:
Witness **:: Name Surname:..... Signature:	Witness **:: Name Surname:..... Signature: