The Eye Institute of Utah
755 East 3900 South, Salt Lake City, UT 84107

Informed Consent for Standard Cataract Surgery

PATIENT NAME: _____ **DOB:** _____ **SURGEON:** _____

CONDITION: I understand that I have a condition with my ☐ right ☐ left eye called a cataract which is a clouding of the natural lens inside of the eye and this is, at least in part, why I am not satisfied with my vision in the affected eye.

PROCEDURE: I understand that cataract surgery may help to improve my vision and that when my cataract surgery is performed, an artificial lens implant (IOL) will be implanted to replace the lens inside of my eye that had developed into a cataract. I also understand that rarely, certain conditions arise during surgery or were present before surgery, that may prevent the surgeon from implanting the type of IOL initially planned for, or even more rarely, any IOL at all. If this is the case, I understand that an IOL can often be implanted with a second procedure at a later time.

BENEFITS: I believe that having this procedure performed will likely improve the vision in my operated eye.

ALTERNATIVES: I can elect not to undergo cataract surgery if I wish.

RISKS: I understand that medicine and surgery are not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the surgery. I understand that one cannot be certain ahead of time how much improvement, if any, there will be in my vision. I understand that glasses may be necessary for reading vision, distance vision, or both, and in rare instances, surgical replacement of the implanted IOL may be indicated. The surgeon has discussed the risks of the planned surgery with me and has answered all of my questions. I understand that complications are rare and include but are not limited to:

- **anesthetic and/or drug reaction**
- **astigmatism**
- **bleeding**
- **clouding/swelling of cornea**
- **dislocation/malfunction of IOL**
- **double vision**
- **epithelial ingrowth**
- **failure to improve vision**
- **glare and/or halos**
- **glaucoma**
- **incorrect IOL power**
- **increased need for glasses**
- **infection**
- **inflammation**
- **iris discoloration**
- **loss of the eyeball**
- **loss of vision – partial or total**
- **low eye pressure**
- **organ damage or death**
- **pain**
- **perforation of the eyeball**
- **ptosis (droopy lid)**
- **pupillary abnormality**
- **retinal detachment**
- **retinal swelling**
- **scarring**
- **vitreous detachment (floaters)**
- **vitreous prolapse**

I understand that videos and/or photographs of my eye and/or procedure may be taken before, during and/or after the surgery solely for scientific / educational purposes. Affiliated healthcare professionals may also be present for teaching purposes.

I understand that I will be required to purchase and use certain eye drops before and after surgery and I agree to follow the recommended drop regimen that will be provided to me to the best of my ability.

I understand that an IOL implant does not necessarily replace the need for glasses and no guarantee has been made regarding specific visual outcomes.

I declare that I fully understand the statements above and that I have made any relevant medical history available to the surgeon including medications, allergy to medications, and any medical conditions requiring treatment.
I wish to have cataract surgery with an IOL in my ☐ right eye ☐ left eye as described above. All of my questions have been answered to my satisfaction. Additionally, if anything is discovered during my surgery which was not anticipated, I permit the surgeon to use his/her best judgment in doing whatever is most appropriate for my care.

Additional surgery which may be needed for my eye includes: _____
and, I wish to have this/these additional procedures performed if my surgeon believes beneficial to me.

My visual preference for my ☐ right eye ☐ left eye is: ___ distance vision ___near vision _____multifocal vision

Patient Signature: _____ Date: _____
(or person authorized to sign for patient)

Witness/Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____
(2nd eye verification) – My signature verifies that I elect to proceed with planned surgery for my second eye.

Witness/Physician Signature: _____ Date: _____

☐ Copy to Patient