Patient Name (print) _____

NOTICE:

PROCEDURES WILL NOT BE SCHEDULED UNTIL WE RECEIVE YOUR COMPLETED CONSENT FORMS

****Please be aware that <u>several pages</u> of the consent forms require your signature****

Please read and complete your consent forms. When completed, please mail back to our office.

It may take up to 10 BUSINESS DAYS after we have received your consent forms to schedule your surgery.

Pre-Operative Health Questionnaire

1. Are you Diabetic? YES / NO
2. Are you currently on dialysis? YES / NO
3. Are you currently taking FLOMAX or any drug to improve your urinary stream? YES / NO
4. Are you currently taking: LANOXIN DIGOXIN
5. Are you currently taking: COUMADIN WARFARIN
6. Please list any allergies to medications and/or medical devices:

   _____

   _____

7. Please list any previous eye surgery:

   _____

   _____

8. Please list your medications:

   _____

   _____

   _____

   _____

INFORMED CONSENT FOR VISOCANNULATION/TRABECULOTOMY
PERFORMED USING **OMNI™ SURGICAL SYSTEM** SURGERY

I authorize Dr. _____ to perform the following procedure described to me in plain language:

Viscocannulation & Trabeculectomy **__Right / Left__** eye

- Surgery to open the natural fluid drainage channel to lower eye pressure.

I have been advised of the following potential benefits:

•Potential lowering of the eye pressure.

•Potentially prevention of further optic nerve damage from elevated pressure.

•Attempt to prevent further visual loss from glaucoma.

I have been advised of the following risks:

Possible infection, pain, bleeding in the eye, swelling, elevated eye pressure, low eye pressure, retinal detachment, need for further glaucoma eyedrops, laser or surgery, injury to other intraocular structures (e.g. change in pupil or cornea), loss of vision, loss of eye.

This procedure will not reverse the damage which has already occurred from glaucoma.

I have been advised of these possible risks if I refuse to undergo procedure:

Potential sustained elevation in eye pressure from goal pressure and further vision loss from glaucoma.

ALTERNATIVE MEASURES

Continue with maximally tolerated medical therapy despite unresponsiveness. Other medical or surgical procedures for lowering eye pressure.

PATIENT ACCEPTANCE OF RISK

I have read the above information, or it was read to me, and I discussed with my physician and I understand it is impossible for the physician to inform me of every possible complication that may occur. My physician has told me that results cannot be guaranteed and that more treatment and/or surgery may be necessary.

By signing below, I agree that my physician has answered all my questions and that I understand and accept risks, benefits and alternatives to surgery. I have been offered a copy of this document. I wish to have a Viscocannulation & Trabeculotomy performed using **OMNI™ Surgical System** operation on my **Right / Left / Both eye(s)**.

_____

Print Patient's Name

_____ _____

Patient's Signature (or person authorized to sign for patient) Date

_____ _____

Witness Signature Date

Dear Patient,

You have been scheduled for surgery at Camp Lowell Surgery Center. Tucson Eye Care has a financial interest in this surgery center. Please inform our staff if for any reason you do not want your surgery performed at this surgery center. You will then be referred to another surgeon who will perform surgery at a different location.

I acknowledge the above and agree to have my surgery scheduled at Camp Lowell Surgery Center.

_____ _____

Patient Signature Date