Denver Eyelid Specialists
Christopher Thiagarajah, MD, FACS · Oculofacial Plastic Surgery

8301 E Prentice Ave, Suite 403
Greenwood Village, CO 80111
Phone (720) 386-1989 · Fax (720) 386-2088

General Consent for Medical and Surgical Procedures

You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. Condition: Dr. _____ has explained to me that the following condition(s) exist in my case:

_____

_____

_____

2. Proposed Procedure(s): I understand that the procedure(s) proposed for evaluating and treating my condition is/are:

_____

_____

☐ **Right eye** ☐ **Left eye** _____

Risks/Benefits of Proposed Procedure(s)

A. Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.

B. I also realize that there are particular risks associated with the procedure(s) proposed for me and that these risks include, but are not limited to, those enumerated in the addendum.

3. Complications; Unforeseen Conditions; Results: I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

4. Acknowledgments: The available alternatives, some of which include _____, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment, _____, have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

5. Consent to Procedure(s) and Treatment: Having read this form and talked with the physicians, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted by hospital personnel and other trained persons as well as the presence of observers.

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

_____ _____
Witness Date

Revised 06/2017

Complications which could occur days, weeks, months, or even years later:

1. Loss of vision
2. Loss of eye
3. Double vision
4. Disfigurement
5. Hemorrhage or infection
6. Failure to solve problem, and possible aggravation of problem
7. Possible necessity for multiple additional procedures, including surgery, chemotherapy and radiation
8. Eyelid malposition, possibly requiring secondary procedure
9. Tearing
10. Possible penetration of sinuses or intracranial space with attendant complications such as meningitis or spinal fluid leak
11. Sensory loss on face

Local complications of anesthesia injections around the eye:

1. Perforation of eyeball
2. Destruction of optic nerve
3. Interference with circulation of retina
4. Possible drooping of eyelid
5. Respiratory depression
6. Hypotension

Additional comments:

Patient (or person authorized to sign for patient)

Date

Witness

Date

Revised 06/2017