Eyesight
Uncompromising Care

**This document will be collected at your Cataract Evaluation appointment and must be on file before you can schedule surgery**

# Informed Consent for Cataract Surgery

This information is given to you to help you make an informed decision about having cataract and/or lens implant surgery. **You will live with the vision resulting from your decisions for the rest of your life, so please read the following explanations carefully.** Once you have read this Informed Consent, you are encouraged to ask any questions you may still have about the procedure. This document will help you understand the risks of cataract surgery.

**WHAT IS A CATARACT?**
The natural lens in the eye can become cloudy and hard, a condition known as a cataract. Cataracts can develop from normal aging, from an eye injury, or if you have taken medications known as steroids. As a cataract develops, it blocks and scatters light, reducing the quality of vision. Cataracts may cause blurred vision, dull vision, sensitivity to light and glare, and/or ghost images. If the cataract changes vision so much that it interferes with your daily life, the cataract may need to be removed. Surgery is the only way to remove a cataract. You can decide not to have the cataract removed. If you don't have the surgery, your vision loss from the cataract may continue to get worse.

**HOW WILL REMOVING THE CATARACT AFFECT MY VISION?**
The goal of cataract surgery is to correct the decreased vision that was caused by the cataract. Cataract surgery will not correct other causes of decreased vision, such as glaucoma, diabetes, or age-related macular degeneration. During the surgery, the ophthalmologist (eye surgeon) removes the cataract and typically puts in a new artificial lens called an Intra-Ocular Lens (IOL).

**UNDERSTANDING THE MAJOR RISKS OF CATARACT SURGERY**

1. RISKS OF THE SURGERY: All operations involve risk and may have unsuccessful results, complications, or injury. Problems with cataract surgery are very rare. There are complications in **FEWER** than 1 in 1,000 of cataract surgeries. Complications may occur weeks, months or even years after surgery.

Problems, while extremely rare, include, but are not limited to, discomfort or pain, droopy eyelids, bleeding; infection; clouding of the outer part of the eye (called the cornea); swelling of the inside layer of the eye (called the retina); detachment of the retina from the eye; increased eye pressure which is also called "glaucoma"; damage to the tissue that supports the lens placed into the eye; and retained pieces of cataract that remain in the eye after surgery. If complications occur, the doctor may decide not to implant the lens in your eye and additional surgeries may be needed. These problems may lead to worse vision, total loss of vision, or even loss of the eye in rare situations.

Dextenza (www.Dextenza.com) is an FDA approved, preservative free, dissolvable, implant, which may be used for certain patients during cataract surgery to reduce pain and/or swelling. Use of Dextenza may help reduce the length of time required for surgical eyedrops to be used postoperatively / after cataract surgery.

Depending on the type of anesthesia, other risks are possible, just like any other surgery, including heart and breathing problems, and, in extremely rare cases, death.



*Initials*_____

Additional surgery may be necessary, even when there are no complications with cataract surgery. You may need a laser surgery to correct clouding of the capsule directly behind the lens (also called a YAG).

At some future time, the lens in your eye may move as a result of the natural aging of the eye, and, although rare, may need to be repositioned with an additional surgery.

2. ISSUES ASSOCIATED WITH THE IMPLANT: Prior to cataract surgery, your eye must be measured to determine the strength of the lens that you require. While this test is very accurate for the majority of patients, some inaccuracies may occur. This problem occurs in only a small percentage of patients, but it would cause the prescription of the eye after cataract surgery to be different than what was expected. Wearing eyeglasses or contact lenses usually solves this. In extremely rare situations, the lens may need to be replaced to correct the strength of the lens.

After cataract surgery it is not uncommon for vision to have some dark shadowing or an “arc” of light in the outer part of the vision. This is called a "dysphotopsia". It is usually temporary and usually resolves on its own. Depending on the type of lens implanted, you may have higher rates of night glare or halos, double vision, impaired depth perception, blurry vision, or trouble driving at night.

3. Cataract surgery is performed one eye at a time. During the time between surgeries, there can be an imbalance between the eyes that can make glasses not work well. This imbalance can cause eye strain and tired eyes. Surgery in the second eye can fix this.

4. There are other eye problems that can affect vision after surgery, like glaucoma, diabetes in the eye, macular degeneration, or your individual healing after surgery. The results of surgery cannot be guaranteed. There is no guarantee of "20/20 vision."



*Initials*_____

# PATIENT CONSENT

**Please copy the following sentences, as they appear, prior to the consultation.**

"I understand there are risks of surgery including vision loss."

_____

_____

"I understand I may need more than one surgery per eye."

_____

_____

"I understand I may not have 20/20 vision after surgery."

_____

_____

| _____ | _____ | _____ |
|---|---|---|
| Patient name (printed) | Patient Signature | Date |

If cataract surgery is scheduled, I authorize the following individuals to communicate with the surgical center on my behalf. However, I understand that only I can answer medical questions unless a medical DPOA is active and on file.

| Name of person | Relationship to patient | Phone Number |
|---|---|---|
| Name of person | Relationship to patient | Phone Number |

Representatives may be from Coastal Surgical Center, Wentworth Douglass Hospital, Frisbie Memorial Hospital, or Exeter Hospital depending on where my procedure is scheduled.

After your Cataract Evaluation, you may want to schedule surgery. To help us schedule your surgery at the appropriate location, please fill out the questionnaire below. Your surgeon will review your answers during your cataract evaluation.

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# ANESTHESIA QUESTIONNAIRE

*REQUIRED FOR ALL SURGERY PATIENTS PRIOR TO SEEING YOUR SURGEON*

**Name**_____ Date_____

**Name of PCP** **Cardiologist** **Optometrist**

| | | |
|---|---|---|
| 1. Have you had any cardiac event within the last 60 days (including heart attack/MI, cardiac stent placement, or cardiac bypass surgery)? | ☐ Yes | ☐ No |
| If yes, date of cardiac event: | _____ | |
| 2. Have you had a stroke or TIA (mini stroke) in the last 3 months? | ☐ Yes | ☐ No |
| If yes, date of stroke or TIA (mini stroke): | | |
| 3. In the last 3 months, have you had any sort of seizure? | ☐ Yes | ☐ No |
| If yes, date of seizure? | _____ | |
| Are you taking any medication to prevent a seizure? | ☐ Yes | ☐ No |
| If yes, what is the name of the seizure medication? | _____ | |
| 4. Are you currently undergoing medical workup for chest pain, shortness of breath, abnormal heart rhythm, heart valve conditions, seizures, strokes/TIA (mini strokes), or a clotting disorder? | ☐ Yes | ☐ No |
| If you are currently being worked up for these conditions, when do you anticipate completing your evaluation? | _____ | |
| 5 . Do you have difficulty lying flat on your back without discomfort or difficulty breathing? | ☐ Yes | ☐ No |
| 6. What is your height? | _____ft | _____in |
| What is your most recent weight? | _____ lbs. | |
| 7. Do you take Wegovy, Ozempic, Mounjaro, or other GLP-1's? | ☐ Yes | ☐ No |
| 8. Do you require continuous oxygen therapy for any breathing disorder (for example COPD, emphysema, pulmonary fibrosis)? | ☐ Yes | ☐ No |
| 9. Are you currently on any form of dialysis? | ☐ Yes | ☐ No |
| 10. Do you have difficulty with shortness of breath or weakness doing everyday activities (such as walking, cleaning, showering, etc.?) | ☐ Yes | ☐ No |
| 11. Have you been to a cardiologist in the last 3 years? | ☐ Yes | ☐ No |
| If yes, for what reason? | _____ | |
| 12. Have you been hospitalized or evaluated in the ER for any reason within the last month? | ☐ Yes | ☐ No |
| If yes, then where? | _____ | |
| 13. Are you currently receiving radiation or chemotherapy for metastatic cancer? | ☐ Yes | ☐ No |
| 14. Have you had an allergic or adverse reactions to the medications Versed (midazolam), Propofol, or opioid pain medications? | ☐ Yes | ☐ No |
| If yes, what medications? | _____ | |
| What was the reaction you had? | _____ | |
| 15. Do you have any of the following: | ☐ Yes | ☐ No |

☐ Implantable Defibrillator ☐ Implantable Pacemaker ☐ Combined Defib/Pacemaker ☐ None

**Please give this form to the technician or the doctor during your appointment.**

**STOP HERE – THE FOLLOWING PAGES NEED TO BE COMPLETED WITH YOUR SURGEON**

# Lens Choice and Informed Consent for Cataract Surgery


**- THIS PORTION SHOULD BE COMPLETED WITH YOUR SURGEON – PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT**

**Please indicate which lens selection you and your doctor have agreed on. You only need to complete the section that applies to your agreed upon lens choice:**

_____ *Initials*

**STANDARD LENS FOR *DISTANCE* VISION:** I wish to have cataract surgery with a STANDARD lens for **DISTANCE** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*
☐ *With Optiwave Refractive Analysis (ORA)*

_____ *Initials*

**TORIC LENS FOR *DISTANCE* VISION**: I wish to have cataract surgery with a TORIC lens for **DISTANCE** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

*Please rewrite the following sentence*: **"I will need glasses for all near and intermediate tasks."**

_____

_____

_____ *Initials*

**STANDARD LENS FOR *NEAR* VISION:** I wish to have cataract surgery with a STANDARD lens for **NEAR** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*
☐ *With Optiwave Refractive Analysis (ORA)*

_____ *Initials*

**TORIC LENS FOR *NEAR* VISION** : I wish to have cataract surgery with a TORIC lens for **NEAR** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

*Please rewrite the following sentence*: **"I will need glasses for all distance and intermediate tasks."**

_____

_____

_____ *Initials*

**STANDARD LENS WITH ASTIGMATISM:** I have astigmatism and/or a prism in my glasses and wish to have cataract surgery with a STANDARD LENS on my (*check one*)

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

*Please rewrite the following sentence*: **"I will need to wear glasses for all tasks after cataract surgery."**

_____

_____

_____ *Initials*

**PANOPTIX, VIVITY, OR LIGHT ADJUSTABLE LENS (LAL) FOR RANGE OF VISION**:
I wish to have a PanOptix, Vivity, OR LAL lens for on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

*** Although this option will give me the most freedom from spectacles, it is possible that even after successful cataract surgery, glasses will be required for some, or all, visual tasks.*

*Please rewrite the following sentence*: **"I may still need glasses for reading or in dim light."**

_____

_____

**PATIENT'S ACCEPTANCE OF RISKS:**
***The main rationale for cataract surgery is to improve the quality of vision. I understand there are no guarantees, and I may still need glasses for some or all ranges of vision, regardless of my lens choice for surgery.***

***Initials_____***

After meeting with my surgeon: I understand that it is impossible for the doctor to inform me of every possible complication that may occur. In signing below, I acknowledge that I have read the preceding pages and agree that the doctor has answered all my questions to my satisfaction. I understand the risks, benefits, and alternatives complications of cataract surgery, as explained to me by my ophthalmologist, and I have been offered a copy of the consent.

| | | |
|---|---|---|
| Patient Name (Printed) | Patient Signature | Date |
| Ophthalmologist | Date | |

*Please note: Your procedure cannot be scheduled until this consent form is signed and a lens choice is finalized. We understand this is an important decision — if you need to change your lens selection, please notify us at least 7 days before surgery so we can confirm availability and allow your surgeon time to recalculate. Requests made less than 7 days prior to surgery may result in a rescheduled surgery date(s).*