CONSENT FOR PHOTOTHERAPEUTIC KERATECTOMY

Dr. Olkowski, Dr. Makin and/or Dr. Gapsis has described to me a procedure called Phototherapeutic Keratectomy (PTK). PTK is done by using the Excimer Laser. The Excimer Laser is used to remove scars, smooth the surface of the cornea, treat cornea erosions or change the shape of a cornea that has been distorted by injury or surgery. PTK removes the diseased portion of the cornea. This hopefully will improve vision and comfort of the eye.

PTK lasts anywhere from ten (10) seconds to five (5) minutes. I will be given a topical anesthetic to help ensure that there will be little or no discomfort during the procedure.

Dr. Olkowski, Dr. Makin and/or Dr. Gapsis will put medication in the treated eye and cover it with a contact lens. Following the procedure, there may be some degree of eye pain for a day or two, requiring medication prescribed by Dr. Olkowski, Dr. Makin and/or Dr. Gapsis. I understand that I must be examined closely to assure proper healing of the treated eye.

Benefits: Benefits can include: Relief of pain or restoration of visual function. The benefits of PTK cannot be guaranteed. It is possible the procedure will be of no benefit and may be harmful.

Alternatives: Alternatives include: Living with my current condition, contact lenses, stromal punctures, or selection of another surgical procedure such as a corneal transplant.

Complications and Risks: I understand that my vision may be made worse by this procedure. Complications could include: Loss of sharp vision, increased corneal scarring, increased night glare or corneal infection. Any pre-existing viral infections may reappear with the use of post-operative drops. If the cornea has extensive scars, it is possible that a corneal perforation may occur that could produce other changes such as infections, cataracts or the need for additional surgery. I understand that I must be examined closely to assure proper healing of the treated eye.

I understand that I may choose to live with the limitations and symptoms caused by my condition, _____, and that other surgical alternatives may be available to me. I further understand that the nature of corneal scars and irregularities are so diverse that it is not possible to discuss all possibilities in detail on this form. I have, however, discussed with Dr. Olkowski, Dr. Makin and/or Dr. Gapsis the alternatives that may be available.

PATIENT CONSENT

In giving my permission for excimer laser surgery, I have been advised by Dr. Olkowski, Dr. Makin and/or Dr. Gapsis and understand the items listed below:

1. The surgical removal of the superficial layers of my cornea using the excimer laser has been elected by me as an alternative to other forms of corneal surgery.
2. As with all surgery, I understand the results cannot by guaranteed.
3. I understand Phototherapeutic Keratectomy (PTK) with the excimer laser may increase my need for glasses and may require the use of corrective lenses to achieve my best vision.
4. I understand that although sharper vision and less glare are anticipated, it is possible that glare and clarity may be made worse following this procedure.
5. I understand that for those severe corneal problems, where the surgical option for me is a corneal transplant, excimer laser PTK may not eliminate the need for a corneal transplant.
6. I understand it is impossible to state every possible complication that may occur as a result of this surgical procedure.
7. **I understand that not all the beneficial effects of PTK are currently known**.
8. **I also understand that all the risks and complications are not known.**
9. I acknowledge this disclosure of information has been made to me and that all my questions have been answered to my satisfaction by Dr. Olkowski, Dr. Makin and/or Dr. Gapsis.
10. I have read this form (or it has been read to me) and I fully understand the complications, risks and benefits that can result from PTK Surgery. I realize there are no guarantees with PTK Surgery.

I still however elect to have PTK laser treatment.

_____
Patient Printed Name

_____ _____
Patient Signature Date

_____
Witness Printed Name

_____ _____
Witness Signature Date

_____
Physician's Printed Name

_____ _____
Physician's Signature Date