ROCHESTER REGIONAL HEALTH

□ Linden Surgery Center
□ Rochester Surgery Center
X Westfall Surgery Center

SURGICAL AUTHORIZATION FORM (Informed Consent)

I hereby authorize Dr. Lindahl, who is referred to as "the Doctor" in the rest of this Consent Form, to perform a surgical procedure called **CATARACT EXTRACTION WITH INTRAOCULAR LENS IMPLANT, LEFT EYE** for the following condition/indication: CATARACT

1. The Doctor has explained my condition and the surgical procedure(s) to me in a manner which I understand. He has explained the purpose of the surgical procedure(s) and alternate ways of treating the condition.
2. In addition to the usual risks (such as bleeding or infection) of these surgical or medical procedures, I have been made aware of certain risks and consequences that are associated with the procedure(s). These include but are not limited to: inflammation, failure to improve vision, retinal detachment, risks of anesthesia, clouding of the cornea, macular edema, double vision, and drooping lids.
3. I understand that during the surgical procedure(s), the Doctor may discover a condition which he/she did not know about before the procedure started. Therefore, I authorize the Doctor and/or his/her assistants to perform any additional or different procedures which the Doctor thinks are necessary or advisable while this surgical procedure is being performed.
4. I consent to the administration of local anesthetic, Monitored Anesthesia Care (IV Sedation), regional or general anesthesia by a qualified physician or Certified Registered Nurse Anesthetist as appropriate for the surgical procedure.
5. At the discretion of the Doctor, I consent to the presence of manufacturers' representatives to aid in the service and use of the instrumentation. I understand that at no time will these representatives have patient contact with me during my procedure.
6. I understand that the Doctor may have assistants/associates/students participate/observe with him/her or under his/her supervision during my surgical procedure and related care.
7. I understand that a videotape and/or photos may be made of the procedure, and I consent to this, provided my right to privacy is protected.
8. I understand that no guarantees have been made to me about the result of my surgical procedure.

I have read this form. I understand what it means.

PATIENT SIGNATURE DATE/TIME	* PATIENT REPRESENTATIVE SIGNATURE DATE/TIME
PRINT NAME	PRINT NAME
DOCTOR'S SIGNATURE DATE/TIME	** WITNESS

***** Declaration by Patient Representative: By signing this consent to treatment on behalf of the patient, I affirm and represent to Rochester Surgery Center/Linden Surgery Center/Westfall Surgery Center that I am the appropriate and legally authorized representative of the patient because I am either: (1) a lawful custodial parent or guardian of the minor patient, or (2) the patients' health care agent for this purpose under a valid New York health care proxy. ****** Witness signature needed if patient/patient representative unable to sign name.