

Consent Form: Surgery for Extraocular Muscles

The surgery is performed in order to improve eye position, or head tilt, or eyeball movement, which are not normal, by strengthening or weakening the extraocular muscles, which are responsible for eye movements. Following anesthetics a test is conducted to examine the source of damage to eyeball movements. The test result will sometimes determine the type of surgery required. The surgery does not change the sharpness of vision in each eye directly, and with adults it does not improve vision, but the patient's appearance and sometimes their bi-ocular vision. The surgery may be a stage of treatment in a series of possible treatments, which include among others: using glasses and/or closing one of the eyes as a treatment for amblyopia (lazy eye). These treatments are performed pre- and sometimes even post-surgery. Each surgery one or more muscles is operated on, in each eye or in both, according to their condition. The operation is done under general or local anesthetics.

Patient's name: _____
Last name First name Father's name I.D.

I hereby declare and confirm having received a detailed oral explanation from Dr. _____
Last name First name

regarding the need of an extraocular muscles surgery to correct strabismus of the right / left eye / both eyes*, on one muscle / both muscles* (hereinafter the "**Main Surgery**"). I hereby declare and confirm that I have been given an explanation of the hoped for results of the surgery which include, reduction of strabismus, including gradual or additional improvement or a worsening, meaning reverting to the former state of strabismus, or the appearance of a different type of strabismus. In these cases there is an option of an additional surgery. The post-surgical side effects were explained to me, including pain, discomfort and transient double vision.

In addition, the possible complications and risks involved in the surgery have been explained to me, including: hemorrhaging, infection, muscle injury, double vision, and in very rare cases a deterioration or loss of vision and injury the ocular shape.

I hereby give my consent to carry out the Main Surgery.

In addition, I hereby declare and confirm that it has been explained to me and I understand that it is possible that during the Main Surgery it may turn out that it must be changed or that other or additional lifesaving or damage preventing procedures should be taken, which cannot be certainly or fully anticipated, but their meanings have been clearly explained to me. Therefore, I hereby agree to said expansion, change, or performance of other or additional procedures, including surgical actions, which the institution's doctors find necessary during the Main Surgery.

My consent is also granted for the performance of local anesthesia, having been explained the risks and complications of local anesthetics, including: hemorrhaging, infection, injury to the eye, and in rare cases loss of vision. If it is decided that the Main Surgery is to be performed under general anesthetics I will be provided with an explanations regarding the anesthetics by an anesthesiologist.

החברה לניהול סיכונים ברפואה בע"מ

ההסתדרות הרפואית בישראל
איגוד רופאי העיניים בישראל



I am aware of and consent to having the surgery and all other procedures conducted by whomever may be charged with doing so, in accordance with the procedures and instructions of the institute and I was not promised that they would all or part thereof be conducted by a certain person, so long as they are done with the customary warranty established in the hospital or ambulant medical institution and as stipulated by current legislation.

Date	Time	Patient's signature
Guardian's name (relation)	Guardian's signature (in cases of an incompetent, minor, or mentally ill person)	

I hereby confirm that I have orally explained to the patient / the patient's guardian* all of the above with the necessary specifications and that she/he have signed this consent before me having been convinced that she/he understood my explanations in full.

Doctor's name	License number	Doctor's signature
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* Delete the unnecessary



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