

Las Colinas Ophthalmology Association  
Consent for Photorefractive Keratectomy (PRK)

You have a right, as a patient, to be informed about your condition and the recommended laser surgical procedure. This information is provided so that you may make the decision whether or not to undergo the procedure fully knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. Instead, it is an effort to inform you, so you may give or withhold your consent to the procedure. Your decision whether or not to have this procedure performed on your eye(s) at this time should be based on the information in the VISX Patient Information Booklet as well as conversations with Dr. Klein, and additional risks and complications found on this form.

In giving my permission for the laser surgical procedure, I declare that I understand the following information:

- PRK consists of using the excimer laser which uses an ultraviolet beam of light to remove the top layers of the cornea, thereby reshaping it.
- PRK is an elective procedure and is not reversible. Alternatives to PRK include eyeglasses, contact lenses or other refractive surgery procedures.
- The long-term risks and effects are unknown.
- The goal of PRK with excimer laser is to reduce or eliminate dependence on eyeglasses or contact lenses. However I understand that as with all forms of treatment, the results in my case cannot be guaranteed.
- There is no guarantee that I will completely eliminate my reliance on eyeglasses or contact lenses. It is possible the treatment could result in under-correction, where some degree of myopia (nearsightedness) remains. Or it could result in over-correction causing hyperopia (farsightedness). Or it could result in a change in my astigmatism (irregular corneal curvature). All of these outcomes could require the use of eyeglasses or contact lenses for the best vision.
- If I currently need reading glasses, I will still likely need reading glasses after this procedure. It is possible that dependence on reading glasses may increase, or that reading glasses may be required at an earlier age if I have this procedure.
- Further treatment may be necessary, including steroid eye drops that can cause glaucoma (blindness from increased intraocular pressure) and cataract formation (progressive clouding of the lens requiring surgical removal). A retreatment with the PRK excimer laser may be required for the best vision.
- My best vision even using eyeglasses or contact lenses may become worse.
- There may be a difference in the eyeglasses prescription between the two eyes, making the wearing of eyeglasses difficult or impossible. Fitting and wearing of contact lenses may be difficult or impossible. The vision may be uncorrectable with eyeglasses or contact lenses.
- COMMON (>99%) post-treatment effects are mild discomfort to moderate eye pain, corneal swelling, double vision, foreign body sensation, ghost images, light sensitivity, tearing and burning.

- POSSIBLE (<20%) long-term complications of PRK laser surgery are:
  - Haze – loss of perfect corneal clarity that can cause blurry vision
  - Glare – sensation produced in certain lighting situations, that is greater than normal and can cause discomfort or annoyance
  - Halo – hazy rings surrounding bright light, particularly at night, that can make night driving more difficult
  - Elevation of IOP – intraocular pressure elevations inside the eye can occur due to post-treatment steroid eyedrop use intended to reduce haze and to promote proper healing of the cornea. This complication usually resolves with use of additional anti-glaucoma medications, and also with eventual discontinuation of the post-operative eyedrops.
- INFREQUENT (<5%) complications of PRK include itching, dryness of the eye, inflammation of the cornea or iris, persistent corneal surface defect, corneal scarring severe enough to affect vision, ulceration of the cornea, infection of the cornea, recurrent corneal erosion, drooping of the eyelid, increase of possible infection due to the use of a bandage contact lens in the immediate post-operative period, and glaucoma, even after the post-operative steroid eyedrops have been discontinued.
- RARE (<0.5%) complications of PRK include corneal perforation, cataract formation, infection inside the eye, and possible need for corneal transplant.
- There is a remote possibility of blindness in the operated eye(s).
- There exists a remote possibility of death due to a drug allergy or abnormal heartbeat.
- I understand that the time interval between the eyes undergoing the PRK recommended by the FDA is 3 months. I have decided that I WOULD/WOULD NOT like to have my second eye treated before 3 months after my first eye was treated. I understand that the result in my first eye may change after one month. Specifically the vision without glasses may still become worse due to a regression of the laser effect causing residual myopia. Haze in my cornea may occur even after one month. Should I experience regression of the effect, or delayed haze in my first eye, it is likely to affect the second eye. Waiting 3 months between eyes as recommended by the FDA may allow for recognition of potential problems sooner, thereby possibly altering the treatment of the second eye.

For WOMEN only: I am not pregnant or nursing. I understand that pregnancy could adversely affect my treatment result.

I have read and understood the VISX Patient Information Booklet that has been provided to me. I have spoken with Dr. Klein who has explained PRK, its risks and alternatives, and answered my questions about PRK laser surgery.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, procedure to be performed, risks and hazards involved, and I believe that I have sufficient information to give this informed consent. I certify this form has been fully explained to me, that I have read and understand it, and that all the blank spaces have been filled in.

I voluntarily request **Diane F Klein, MD** as my physician, and such technical associates and other health care providers as deemed necessary, to treat my condition which has been explained to me as:

**MYOPIA, with or without ASTIGMATISM**

By my signature below, I understand the laser surgical procedure planned for me, and I voluntarily consent and authorize this procedure:

**PHOTOREFRACTIVE KERATECTOMY (PRK)**

- RIGHT EYE**
- LEFT EYE**
- BOTH EYES**

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PATIENT SIGNATURE

PRINTED NAME

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WITNESS

PRINTED NAME

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DATE