

Patient Name

DOB:

MR #

**Madison Surgery Center**  
**1 S. Park Street-3<sup>rd</sup> Floor Madison, WI 53715**  
**CONSENT TO PROCEDURES – CATARACT**  
**REMOVAL WITH INTRAOCULAR LENS**  
**IMPLANTATION**

Index to Treatment/Procedures - Surgical

Date: \_\_\_\_\_

I request and allow Dr. \_\_\_\_\_, and/or other doctors, assistants, students, and staff who may be assigned to my care, to perform on: \_\_\_\_\_ the following:  
 (Patient's name or "Myself")

\_\_\_\_\_  
 Cataract Removal with Intraocular Lens Implantation

When the procedure is planned for one side of the body, check the planned side here:  RIGHT  LEFT

I have read page 2 of this form and have crossed out, limited, or made the following changes: \_\_\_\_\_

By signing, I confirm that (1) I have read **both pages of this form**, (2) I understand the form and information given to me by my doctor or doctor's designee, (3) I have had the chance to ask questions and have had them answered to my liking, and (4) I give my consent to perform the operation(s) or procedure(s) listed above. The risks, benefits, and other options have been explained to me. The risks of not having the procedure have also been explained to me and I agree to proceed.

**AUTHORIZING SIGNATURES:**

Signature of Patient/Representative \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient is:  Minor  Incompetent / Incapacitated  
 Legal Authority:  Legal Guardian  Parent of Minor  
 Health Care Agent  Other \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Print Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Pager# \_\_\_\_\_

\_\_\_\_\_  
 Interpreter or Reader Signature (if applicable)

\_\_\_\_\_  
 Witness Signature (if applicable)

\_\_\_\_\_  
 Print Interpreter or Reader Name

\_\_\_\_\_  
 Print Witness Name

\_\_\_\_\_  
 Date Time

\_\_\_\_\_  
 Date Time

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**A doctor has fully explained to me:**

- the nature and concerns of the procedure(s)
- other options for treatment
- possible outcomes
- what may happen if I do not get treated
- risks such as severe loss of blood, infection, and cardiac arrest, that can happen during any procedure

I understand the risk of problems, serious injury or even death that may result from both known and unknown causes.

**I understand/have been told that:**

1. Before, during, or after the procedure listed above, I may develop or the doctor may find new problems that could not be foreseen. These findings may require that more or different procedures be used. I request and allow my doctors to use the procedures they feel are best to care for me.
2. I may get an anesthetic from a member of the Department of Anesthesiology, a resident, a nurse, or the operating surgeon. My options and the risks/benefits of its use have been made clear to me. I consent to the use of such anesthesia. Restrictions, if any, on the type of anesthetic are noted on page 1 of this form.
3. I understand that it is the practice of this surgery center and the physicians providing my care to temporarily suspend "do not resuscitate" (DNR) orders and I agree to such suspension.
4. The independent practitioners who have been granted the privilege of using this facility for the care and treatment of patients are not employees or agents of the surgery center. The University of Wisconsin Hospitals and Clinics and its medical staff have service, educational, and research relationships with the University of Wisconsin Madison and other affiliated health care service and educational institutions. The physicians involved in the care are comprised of medical staff members on the University faculty, residents or fellows in training programs.
5. The practice of medicine, surgery and dentistry is not an exact science. No promises have been made to me about the results of the procedure(s).
6. I consent to have any of the procedure(s) observed, photographed, filmed, televised, or recorded to help improve health care, education or knowledge. I understand that my identity will not be made known by the pictures.
7. I consent to this surgery center keeping or throwing away any tissue or body parts removed during the procedure(s), and for these to be used for research.
8. There may be a need to share or report information about me (the patient), such as HIV, tuberculosis, and other diseases to places such as the state health department.