**Patient details or pre-printed label**

Surname _____

First names _____

Date of Birth _____

NHS and/or hospital number _____

Special requirements e.g. communication:

**For adult patients with mental capacity to give valid consent to**

# Course of injections into back of the eye / Intravitreal injections

# Right eye / Left eye / Both eyes

**Signed copy to be kept in health records, further copy to be given to patient**

**Source of Patient Information & Charities:**

RNIB: https://www.rnib.org.uk/eye-health/eye-conditions/age-related-macular-degeneration-amd#treatment

Macular Society: https://www.macularsociety.org/wet-amd

NHS https://www.nhs.uk/conditions/age-related-macular-degeneration-amd/treatment/

**Hospital eye clinic leaflet – please ask for one if not provided**

**Injection in back of eye/Intravitreal injection Right / Left / Both eyes**

To prevent pain you will be given drops
or other anaesthetic: [ ] injection [ ] general anaesthesia [ ] sedation

The intended benefit: **To improve or stabilise central vision**

Other benefit:

Serious, significant or frequently occurring risks:

- **Common up to 1 in 20, usually temporary**
  - **Red or sore eye**
  - **Corneal abrasion/scratch**
  - **Floaters**
  - **Headache**
- **Uncommon up to 1 in 100**
  - **Inflammation inside eye**
  - **High pressure needing temporary treatment**
- **Rare up to 1 in 1000**
  - **Infection inside eye (1:2000 per injection)**
  - **Bleeding inside eye**
  - **Glaucoma**
- **Vere rare up to 1 in 10,000**
  - **Retina damage (detachment, tear)**
  - **Cataract**
  - **Need for further operation or procedure**
  - **Permanent serious loss of vision**
- **Stroke/Heart attack: uncertain risk**

**Specific or material risks for this patient:**

**COVID-19:** In the majority, COVID-19 causes a mild, self-limiting illness but symptoms may be highly variable amongst individuals and it is important you understand the specific risk profile to yourself. **There is no guarantee of zero risk of COVID-19 transmission. For more information: www.gov.uk/coronavirus**

**Health Professional**: I assess that this patient has capacity to give valid consent. I have discussed what the procedure is likely to involve, the benefits and risks of this and of any available alternative treatments and of no treatment and any particular concerns of this patient. The patient has been given the opportunity to ask questions. I have provided the **Cataract surgery leaflet**.

Signed_____ Date _____

Name _____ Job title _____

**Patient:** Please read this form carefully, it describes the benefits and risks of the treatment. **You will be given a copy of this form** to keep and a copy of an information leaflet about cataract surgery. **Please ask for a leaflet if not offered one.** If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

**I agree** to the procedure described on this form.
**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

**I understand** that any procedure in addition to that described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my general or eye health.

Patient's signature_____ Date_____

Name (PRINT)_____

**Contact name and telephone** if patient wishes to discuss later

_____

**Interpreter** (where appropriate): I have interpreted the information above and the discussions between the patient and the professional to the best of my ability and in a way in which I believe s/he can understand.

Signed_____ Date_____

Name (PRINT)_____

**A witness should sign if the patient is unable to sign but has indicated consent.**

Signed_____ Date_____

Name (PRINT) _____