Consent Form
Patient Agreement to Investigation or Treatment

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Patient Details (or pre-printed label)

Name | D.O.B

Hospital Number

Address

Postcode

Responsible Health Professional

Job Title

Consent Form Date | Consent Form Renewal Date (36 months)

Series of Intravitreal Eye Injections of Anti-VEGF Class Drug (See Supplementary Document for Specific Drug and Site)

Main Intended Benefit

To prevent further loss of central vision. Vision may improve but can also deteriorate despite successful treatment.

Injection Procedure Related Risks

Common problems after treatment (up to 1 in 20 procedures): Temporary pain, redness, soreness, conjunctival haemorrhage (bloodshot eye), visual disturbance such as small specks in vision (floaters).

Low risk approximately 1-5 per 100 patients (dependent on drug used).

i) Eye Inflammation. Milder levels of eye inflammation which may be controlled with additional treatment.
ii) Raised eye pressure.

Very low risk – less than 1 in 1000 procedures. Potentially serious sight threatening risks:

i) Severe eye inflammation or infection (Endophthalmitis)
ii) Retinal Detachment
iii) Injury to lens during injection procedure causing cataract

Complications of drug in other body parts (very unlikely):

A theoretical increased risk of problems such as heart attack or stroke.

Anaesthesia

The procedure will require local anaesthesia.

Any extra procedure that may become necessary during the procedure:

Release of intra-ocular fluid by corneal incision.

Statement of health professional

(To be completed by a health professional with appropriate knowledge of proposed treatment or surgery).

I assess that this patient has capacity to give valid consent. I have explained the above procedure to the patient, including what is likely to be involved, benefits, risk and any alternative options including the implications should the patient choose not to proceed with treatments, and I have discussed any particular concerns raised to me by the patient. I have also discussed any off-label drug requirements.

I have provided the patient with the following written information:

The contents of this consent form along with the written patient Information have been discussed with the patient, and the patient has agreed to read (or have read to them) the patient information provided to them.

Signed Date

Name (PRINT) Job title

Statement of Patient

This information should be read carefully. If you have any further questions, please ask a member of the team. You have the right to change your mind at any time, including after you have signed this form.

- I agree and consent to the treatment indicated in this consent form
- I am satisfied that I have understood the risks and benefits of injection treatment to the extent that I am willing to proceed with treatment with the information that I have at present (the main benefits and risks of the procedure are outlined briefly on the first two pages of this consent form)
- The benefits, risks and complications of my injection treatment have been explained to me to my satisfaction, and in a way that I have understood. I have also had explained to me the implications of deciding not to proceed with treatment.
- I understand that it would be impossible to have every conceivable outcome and complication explained, but I have had all my questions answered to my satisfaction, so that I can make an informed decision to proceed with injection treatment.
- 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 those described in this form will only be carried out if it is necessary to prevent serious harm to my health
- I have been informed about additional procedures which may become necessary during my treatment

Patient's Signature _____ Date _____

Name (PRINT) _____

Signature of Witness (where required)

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

Signature _____ Date _____

Name (PRINT) _____ Relationship to Patient _____

Statement of Interpreter (where required)

I have discussed the information above to the patient to the best of my ability and in a way in which I believe the patient can understand.

Signature _____ Date _____

Name (PRINT) _____ Relationship to Patient _____

☐ Copy has been provided to patient. (please tick box)