Consent Form

Patient: _____
(Full Name)

Proposed Treatment: CATARACT EXTRACTION WITH IOL IMPLANTATION

☐ I believe that the above patient is *capable* with respect to the proposed treatment.

☐ I believe that the above patient is *incapable* with respect to the proposed treatment and

Substitute Decision Maker is :

_____
(Name of Substitute Decision Maker)

Dr. D. Lane		
Physician / Dentist / Midwife (please print)	Date	Physician / Dentist / Midwife Signature

I hereby CONSENT to undergo the above treatment/procedure/operation ordered by or performed by the above health practitioner.

Dr. D. Lane
Name of Physician / Dentist / Midwife has explained to me the nature, the expected benefits,

the material risks and the material side effects of the treatment/procedure/operation as well as the alternative courses of action including the likely consequences of not having the treatment/procedure/operation.

I understand the explanation and am satisfied that my questions have been answered.
I also consent to such additional or alternative treatments as in the opinion of the above physician, dentist or midwife are immediately necessary and I further agree that in his or her discretion, the physician, dentist or midwife named above may make sure of the assistance of other appropriately qualified health care providers and employees to complete the authorized treatments listed above and other procedures deemed immediately necessary.

Dated this _____ day of _____ , 20_____

Signature of Patient (or Substitute Decision Maker, if applicable)	Name of Substitute Decision Maker, if applicable)
Signature of Witness of Patient or Substitute Decision Maker	Name of Witness

EMERGENCY WAIVER

Consent waived for the following reason _____

_____

_____

Signature of Physician / Dentist / Midwife