PRIVATE AND CONFIDENTIAL
WITHOUT PREJUDICE – NOT FOR PUBLICATION

GAGAN J. SINGH, M.D.
CONSENT TO OPERATIONS
ANESTHETICS, AND OTHER MEDICAL SERVICES

Date: _____ Time: _____ am / pm

1. I authorize the performance upon (Name) _____ of the following operation, **Argon Laser Pan Retinal Photocoagulation** of the Left / Right eye, to be performed by or under the direction of Dr. Gagan J. Singh, his/her professional partner(s) or designates at The Medical Eye Center.

2. The nature and purpose, the operation(s) or procedure(s), possible alternative methods of treatment, the potential risks involved, and possible consequences have been explained to me by Dr. Singh. These include, but are not limited to **increase in eye pressure, bleeding, loss of vision, failure to achieve desired result, and the need for further surgery and laser treatments.**

3. I have been advised of the serious nature of the operation(s) and have been advised that if I desire a further and more detailed explanation of any of the foregoing or further information about the possible risks or complications of the above listed operation(s), it will be given to me.

4. I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above-named doctor or his/her associates or assistants may consider necessary or advisable in the course of the operation.

5. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the service with the exception of (STATE SPECIFICS)

   _____

6. I acknowledge that no guarantee or assurance has been given by anyone as to the result that may be obtained as a result of the operation(s) or procedure(s) to be performed.

7. I consent to the release of my Social Security Number to the manufacturer(s) of any implantable device I receive.

8. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.

9. For the purpose of advancing medical education. I consent to the admittance of observers to the operating room.

10. I consent to the disposal by Gagan J. Singh, M.D., of any tissues or body parts, which may be removed.

11. I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing. And I do not request a further and more detailed listing and explanation of any of the items listed in paragraph 2 above.

12. Other comments: _____

13. **Alternative**: Continue with current vision.

(CROSS OUT ANY PARAGRAPHS WHICH DO NOT APPLY)

Physician _____, M.D.
(The physician whose signature appears above has explained the procedure to the patient)

Signed: _____
(Patient / Person authorized to sign)

Witness: _____
(The individual named above is witness to patient signature)