UKOA UK OPHTHALMOLOGY ALLIANCE

The ROYAL COLLEGE of OPHTHALMOLOGISTS

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

Corneal transplantation –

Deep anterior lamellar keratoplasty (DALK)

Right eye / Left eye

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

Source of Patient Information & Charities:

NHS: https://www.nhs.uk/conditions/cornea-transplant/

https://www.moorfields.nhs.uk/sites/default/files/Corneal%20transplantation%20-%20DALK.pdf

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

Corneal transplantation **Right eye / Left eye**

Deep anterior lamellar keratoplasty (DALK)

You will receive general anaesthesia [ ]
local anaesthesia [ ] sedation [ ]

The intended benefit: **To improve vision or comfort**
Other benefit:

Serious, significant or frequently occurring risks:

Common up to 1 in 3

- **Convert to full-thickness corneal transplant**

Common up to 1 in 5

- **Stitch-related problems**
- **Graft rejection in the first year (treatable in most patients)**
- **Delayed healing**

Common up to 1 in 10

- **Graft failure in the first year (graft clouding which reduces vision)**
- **Glaucoma (high pressure needing treatment or affecting sight)**
- **Further surgery in the first 3 years, including repeat corneal graft**

Uncommon up to 1 in 100

- **Inflammation or bleeding inside eye, usually gets better with time**
- **Damage to iris**
- **Recurrence of underlying disease**
- **Infection in graft**

Rare up to 1 in 1000

- **Retina problems (detachment, fluid build-up)**
- **Serious infection inside the eye, may lead to severe loss of sight**
- **Severe bleeding at back of eye**
- **Severe or permanent vision loss**

Very rare up to 1 in 10,000

- **Inflammation which could affect vision in both eyes**
- **Infection in other parts of the body which could cause serious health issues.**

Specific or material risks for this patient:

Has the patient ever been told by their doctor or by the public health authorities that they may be at risk of having CJD?

☐ No	Proceed as normal
☐ Yes	Ask for further explanation *
☐ Unable to respond	Proceed as normal unless high risk tissue *

* Quarantine instruments pending advice from with infection control

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 **Corneal transplantation – Deep anterior lamellar keratoplasty 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 Corneal transplantation – Deep anterior lamellar keratoplasty leaflet. **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 number 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)____