

**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 – Descemet's stripping  
endothelial keratoplasty (DSEK)**

**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-%20EK.pdf>

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

## **Corneal transplantation –**

**Right eye / Left eye**

### **Descemet's stripping endothelial keratoplasty (DSEK)**

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 10**

- **Graft separation or partial separation requiring further surgery**
- **Graft failure in the first year (graft clouding which reduces vision)**
- **Glaucoma (high pressure needing treatment or affecting sight)**
- **Inflammation or bleeding inside eye, usually gets better with time**
- **Damage to iris**

#### **Uncommon 1 in 20**

- **Graft rejection in the first year (treatable in most patients)**

#### **Uncommon up to 1 in 50**

- **Delayed healing**

#### **Uncommon up to 1 in 100**

- **Infection on the eye surface**

#### **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 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?**

- |  |   |
|--|---|
| <input type="checkbox"/> No                | Proceed as normal                           |
| <input type="checkbox"/> Yes               | Ask for further explanation *               |
| <input type="checkbox"/> 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](http://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 – Endothelial 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 – Endothelial 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

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**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) \_\_\_\_\_