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

Macular hole repair

Right eye / Left eye

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

Source of Patient Information & Charities:

Macular Society: https://www.macularsociety.org/macular-hole

RNIB: https://www.rnib.org.uk/eye-health/eye-conditions/macular-hole

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

Macular hole repair: **Right eye / Left eye**

Vitrectomy, internal limiting membrane peel +/- cryotherapy / laser retinopexy +/- gas

To prevent pain you will be given drops
or other anaesthetic: [ ] injection [ ] general anaesthesia [ ] sedation

The intended benefit: **To close macular hole and improve vision**

Other benefit:
Some patients may be asked to do positioning after the surgery to improve the success of surgery. We will advise you ahead of your surgery if this will be necessary.

Serious, significant or frequently occurring risks:

Common up to 1 in 20

- **Failure to close macular hole or improve vision (between 5% to 20% depending on how long macular hole has been present)**
- **Inflammation**
- **Raised eye pressure (usually temporary)**
- **Swelling of centre of retina affecting vision (usually temporary)**
- **Cataract (within 18 months which may need surgery)**
- **Ongoing distortion of vision**
- **Retinal tears**
- **Need for further surgery**

Uncommon up to 1 in 100

- **Retinal detachment**
- **Retinal damage affecting sight**
- **Severe loss of vision**
- **Glaucoma (high pressure needing treatment or affecting sight)**

Rare up to 1 in 1000

- **Serious infection inside eye, may lead to severe loss of sight**
- **Bleeding into the eye, may lead to severe loss of sight**

Very rare up to 1 in 10,000

- **Severe inflammation or loss of vision in the other eye**

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 **Macular Hole Surgery 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 macular hole surgery. **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)_____