

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
Retinal detachment 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:

<https://www.nhs.uk/conditions/detached-retina-retinal-detachment/>

https://www.rcophth.ac.uk/wp-content/uploads/2017/10/2017_Understanding-Retinal-detachment_v04.pdf

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

Retinal detachment repair:**Right eye / Left eye****Vitrectomy +/-cryotherapy / laser retinopexy +/- gas or silicon oil**

To prevent pain you will be given drops and/or another anaesthetic option: injection general anaesthesia sedation

The intended benefits: **to stick down the retina, to prevent future retinal detachment and to protect or improve vision.**

Other benefits:

Important considerations:

Vision recovery: may be full or partial depending on whether the central vision has been affected and may take months.

Positioning: Some patients are required to do some 'positioning' after the surgery. This will be confirmed after your surgery and may increase the success of surgery or reduce the risk of distorted vision.

Gas in Eye: The eye may be filled with gas after surgery that usually goes away on its own within 2-8 weeks, depending on the gas used. The vision is poor until the gas is gone.

Oil in Eye: The vision will be blurry whilst oil is in the eye. Another operation is required to remove the oil but in some cases silicon oil needs to be replaced or kept in the eye to keep the retina stuck down.

Restrictions: Air travel, going to high altitude and having a general anaesthetic with nitrous oxide (an anaesthetic gas) are prohibited until the gas clears completely, as the gas can expand and cause immediate sight loss and pain.

Serious, significant or frequently occurring risks:

Very common more than 1 in 10

- **Re-detachment of retina**
- **Cataract (within 18 months) in most patients - may need surgery**
- **Need for further surgery**

Common up to 1 in 20

- **Inflammation (usually temporary)**
- **Raised eye pressure (usually temporary)**

- **Problems with the centre of retina affecting or distorting vision: swelling (usually temporary) or membrane (usually permanent)**

Uncommon up to 1 in 100

- **Retina injury affecting sight**
- **Distortion of vision**
- **Severe loss of vision**
- **Glaucoma (high pressure needing treatment or affecting sight)**
- **Double vision (may be more common in the first 3 months but usually resolves)**

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**
- **Freeze damage to the wall of the eye**

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?

- | | |
|--|---|
| <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 of people, COVID-19 causes a mild, self-limiting illness. However, some people get a more severe form of the disease and it is important you understand your specific risk.

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 **Retinal detachment repair 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 retinal detachment repair. **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) _____