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

Trabeculectomy [ ] Right eye / Left eye [ ]

[ ] with anti-metabolites ([ ] Mitomycin C / 5FU [ ])

[ ] with anti-VEGF

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

Source of Patient Information & Charities:

International Glaucoma Association: https://www.glaucoma-association.com/media/wysiwyg/Leaflet_PDF_Files/Trabeculectomy.pdf

NHS.net: https://www.glaucoma-association.com/media/wysiwyg/Leaflet_PDF_Files/Trabeculectomy.pdf

https://migs.org/wp-content/uploads/Trabeculectomy.pdf

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

Trabeculectomy **Right eye / Left eye**

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

The intended benefit: **To lower the eye pressure to prevent worsening of glaucoma and loss of sight.**

Serious, significant or frequently occurring risks:

Most patients will need to attend the clinic frequently for the first month and then several times over the next few months.

Patients might need some minor procedures whilst sitting at the slit lamp with local anaesthetic e.g. stitch removal, injections or needling to prevent scarring, etc.

Formatted: Font: 12 pt

Common risks up to 1 in 20

- Pressure can be too high at any time (need for removal of stitches, needling, more surgery etc.)
- Pressure can be too low at any time (need for gel injections or more surgery etc.)
- Bleeding inside the front of eye (usually temporary and recovers)
- Leak or opening in the draining blister (at any time)
- Inflammation of the eye
- Cataract
- Change in vision due to change in the shape of the eye, low eye pressure or bleeding inside the eye. This is usually temporary but occasionally permanent.
- Droopy eyelid

Uncommon up to 1 in 100

- Bleeding at back of eye seriously affecting vision (temporary or permanent)
- Uncomfortable or visibly prominent draining blister

Rare up to 1 in 1000

- Serious infection of the blister or inside the eye (endophthalmitis), can cause permanent severe loss of vision
- Loss of vision which may be severe due to very low or high pressures after surgery
- Double vision

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 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.
We cannot guarantee 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. I have also discussed the option of no treatment and any particular concerns of this patient. The patient has been given the opportunity to ask questions. I have provided the **Trabeculectomy 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 **Trabeculectomy** 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)_____