

POST-OPERATIVE CATARACT INSTRUCTIONS



1. VIGAMOX

- One drop 4 times a day.



2. OMNIPRED

- One drop 4 times a day.
- Shake bottle well before use.



3. NEVANAC

- One drop 4 times a day.
- Shake bottle well before use.

DIRECTIONS:

- Space Nevanac and Omnipred drops evenly throughout waking hours. (e.g. breakfast, lunch, dinner, bedtime)
- Wait 5 minutes in between drops.
- Gently close eyes for 1 minute after instillation of each drop.
- Wear eye shield while sleeping.
- If you are presently using any other drops (e.g. glaucoma drops) you will need to continue them unless otherwise specified.

IMMEDIATELY REPORT ANY CHANGES WITH YOUR EYES. EXAMPLES ARE DECREASED VISION, PAIN OR INCREASED REDNESS.



POST-OPERATIVE CATARACT INSTRUCTIONS

The following information should be helpful concerning the care of your eyes at home. If further explanation is required, PLEASE call our office.

1. You will be given an appointment to be seen in the office on the day following surgery. Please make every effort to keep all post-operative appointments.
2. DO NOT REMOVE THE CLEAR SHIELD, AND BRING YOUR DROPS WITH YOU TO THE OFFICE TOMORROW.
3. Use a clean, warm washcloth to cleanse the eyes of any excessive mattering.
4. Avoid rubbing, touching, or bumping the eye at all times.
5. Put the eye shield on at bedtime.
6. Wear dark glasses as needed to ease glare.
7. No heavy lifting over 20 pounds for two weeks.
8. Using the eyes will not harm them.
9. You may wash your hair in the shower.
10. Do not drive an automobile for two to three days. Do not operate any heavy machinery for 24 hours.
11. You may sleep on either side.
12. You may bend over and put on shoes, etc ...
13. Call the office immediately if excessive or unusual pain, redness, swelling, or drainage persists.
14. After surgery, it is normal for the white part of the eye to appear red or bloodshot. Do not worry; this will clear in several weeks.
15. Notice how well you are seeing each day. Temporary "floaters" or "red or pinkish" vision is not uncommon immediately after surgery. Your vision should gradually improve. Notify us immediately if your vision gets abruptly worse or if a shower of new floaters or flashes develops.
16. Your pupil will be very small or "pinpoint" for the first few days after surgery. As a result, your vision may seem dark and blurred. This generally clears in 2-3 days.
17. Do not drink any alcoholic beverages for 24 hours.
18. Do not sign or make any legal/personal decisions for 24 hours.

Your first follow-up appointment is scheduled: _____

Patient's Signature: _____ Date: _____

VEISC Representative Signature: _____ Date: _____



AUTHORIZATION FOR MEDICAL AND OR SURGICAL TREATMENT

Date: _____ 20 _____ Time: _____ am/pm

I, _____, as a patient in the Valley Eye Institute Surgery Center, hereby authorize my surgeon (and whomever he may designate as his assistants) to administer such treatment as is necessary, and to perform the following operation.

Cataract Extraction With An Intraocular Lens Implant On My Right/Left Eye

And such additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course or said operation.

Anesthesia: In addition, I consent to the administration of anesthesia as explained to me by my surgeon. I understand that my surgeon will supervise the administration of the anesthesia and that other anesthesiologists or certified nurse anesthetist may be involved in my care.

My surgeon explained the administration of intravenous conscious sedation, deep intravenous sedation, and/or nerve block anesthesia. I have had the opportunity to ask my surgeon questions, and these were answered to my satisfaction. I understand that common complications of anesthesia include nausea, vomiting, headache, sore throat, numbness, or tingling. More serious but rare complications include heart and lung problems, heart attack, stroke, malignant hyperthermia, and death. My vital signs, including electrocardiogram, blood pressure, oxygen saturation and breathing, temperature and level of consciousness, will be monitored continually to help ensure my safety.

I consent to the photographing of me or parts of my body in connection with the above procedure for medical, scientific or educational purpose provided my identity is not revealed by the pictures or by descriptive texts accompanying them. All photographs may be taken only with the consent of my surgeon.

I further consent to and authorize the lawful disposal of any tissues or body parts which may be removed.

I hereby certify that I have read and fully understand the above Authorization for Medical and/or Surgical Treatment. The reasons why the above named surgery is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by my surgeon.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I acknowledge that this facility has waived all advanced directives.

I also certify that I am aware that my surgeon has a financial investment in Valley Eye Institute Surgery Center.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor, or when the patient is physically or mentally incompetent.

I (we) hereby certify that I am the parent, guardian, custodian, nearest relative of the patient named above and have executed the authorization on their behalf.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If not signed by the actual patient, give a brief explanation why.
