ACCEPTANCE OF RISK AND INFORMED DECISION AGREEMENT

To the patient: This is the last step in deciding whether you want to have intraocular telescope surgery. This Agreement lists important risks of intraocular telescope surgery. Please review this Agreement carefully with your eye surgeon. You should sign this Agreement only if you are satisfied that each risk has been explained to you and you understand and accept each risk. If you accept each risk and sign the Agreement, it means you have decided to have intraocular telescope surgery. You must accept each risk and sign the Agreement before you can have intraocular telescope surgery.

To the eye surgeon: Please review this Agreement carefully with your patient. For each item, initial if you are satisfied that the patient understands the item and has accepted it. Your signature confirms that the patient has completed and signed the Agreement.

	Patient Initials	Physician Initials
I understand that the intraocular telescope is implanted in only one eye. The eye with the intraocular telescope provides central vision. I will need to use my other eye for peripheral vision when I want to walk around.	_____	_____
I used an external telescope to see if my vision would improve with magnification and it did. I find the vision acceptable.	_____	_____
I had training in the use of an external telescope to see whether I can adjust to using one eye for central vision and the other eye for peripheral vision. I was able to do this with practice.	_____	_____
I understand that my ability to use the external telescope does not guarantee that I will be able to successfully use the intraocular telescope.	_____	_____
The field of view in the eye implanted with the intraocular telescope is restricted. I understand that I will lose peripheral vision in the eye implanted with the intraocular telescope and that I will need to rely on my other eye for peripheral vision.	_____	_____
I understand that I may experience double vision after intraocular telescope surgery.	_____	_____

ACCEPTANCE OF RISK AND INFORMED DECISION AGREEMENT (continued)

	Patient Initials	Physician Initials
I understand that if I have intraocular telescope surgery, I will need training to learn to use the intraocular telescope. I agree to attend such training.	_____	_____
I understand that after intraocular telescope surgery, I will probably need glasses to adjust my near and distance vision.	_____	_____
I understand there may be problems during surgery that may prevent my surgeon from implanting the intraocular telescope. If this happens, I understand that I may receive an intraocular lens (IOL) instead of the intraocular telescope. This means that I will have all the surgical risks, but I will not get the benefits of the intraocular telescope.	_____	_____
I understand that instead of the intraocular telescope improving my vision, my vision could get worse.	_____	_____
I understand that with the intraocular telescope implanted in my eye, my eye doctor may not be able to see parts of my eye or perform some procedures I may need in the future.	_____	_____
I understand that having the intraocular telescope could cause corneal edema. This could happen at any time, even 5 or more years after my surgery, and require me to have corneal transplant surgery.	_____	_____
If I have to have a corneal transplant, I understand that I may not be able to keep the intraocular telescope in my eye.	_____	_____
My eye surgeon gave me the Patient Information Booklet on the intraocular telescope. I have had the chance to discuss the information in the Patient Information Booklet with my eye doctor, my eye surgeon, my family and my friends.	_____	_____

ACCEPTANCE OF RISK AND INFORMED DECISION AGREEMENT (CONTINUED)

I have had enough time to read and understand the information in the Patient Information Booklet. My eye doctor and eye surgeon have answered my questions. I have considered alternatives to the intraocular telescope such as external telescopes, spectacle mounted telescopes, and special magnifying eyeglasses.

I choose to proceed with surgery to implant the intraocular telescope.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Surgeon Name (Printed): _____

Surgeon Signature: _____

Date: _____

Witness Name (Printed): _____

Witness Signature: _____

Date: _____