Consent Form

1. I understand that I am a candidate for LASIK (LASER IN SITU KERATOMILEUSIS) SURGERY, a form of outpatient laser surgery where a surgeon will anesthetize my eye with a topical anesthetic, create a flap from my cornea using a specialized instrument called a microkeratome, and use an excimer laser to reshape the cornea.

Patient Initial for LASIK: ____________________

OR

2. I understand that I am a candidate for PRK (PHOTOREFRACTIVE KERATECTOMY) SURGERY, a form of outpatient laser surgery in which a surgeon uses a device called an excimer laser to reshape the cornea.

Patient Initial for PRK: ______________________

LASIK or PRK, the identified surgery, is referred to as the "Procedure" in the following.

3. I understand the Procedure will be performed by __________________________ M.D., ("my surgeon") at Coal Harbour Eye Centre (the "Centre"). On this ________ day of ________________________ 2001.

(i) both eyes [INITIAL] ____________________; **or**

(ii) on ________________________(DATE) my right eye

[INITIAL] _________________; and on

_________________________ [DATE] on my left eye

[INITIAL] _________________

4. I have reviewed the Surgical Information Package for LASIK surgery and for PRK and I have discussed the Procedure that I am to receive with an eye care professional at the Centre, and will ask the surgeon any questions that I still may have.

5. The nature of the Procedure, the possible complications and risks, as well as the possible benefits of the Procedure, the alternatives to the Procedure and the risks and benefits of those alternatives have been explained to me in language and using terminology that I understand.

6. I understand that this Procedure is an elective surgical procedure, and that there is no emergency or medical condition that requires that I have the Procedure.

7. Neither my surgeon, nor my optometrist, nor the Centre staff has made any promises or warranties or guarantees as to the success or effectiveness of the Procedure. I have been advised that after the Procedure, my vision may not be as clear and sharp as it was with glasses or contact lenses before the Procedure.

8. I understand that the Procedure may not eliminate the need for corrective lenses for all activities and that after the Procedure, I may need glasses or contact lenses for reading, driving or certain other activities, even if I did not wear them before. I also understand that the Procedure can unmask the need for reading glasses, and that I may have to use them after the Procedure, even if I did not wear them before.

9. I understand that after the Procedure I may experience side effects such as pain, discomfort and scratchiness, halos, blurry vision or fluctuations in vision, which may be temporary or could be permanent. I have been advised that I may find some of these side effects difficult to tolerate.

10. I understand that there are numerous risks and complications, both known and unknown connected with the Procedure, including but not limited to infection, hemorrhage, delayed healing, under or over correction, and other risks and complications that could affect my vision and my general health on a temporary or permanent basis, and could require additional surgery, including, but not limited to, re-treatment or a cornea transplant. Those risks also include, but are not limited to, partial or total blindness, loss of a cornea, retinal damage or loss of an eye.

11. I understand that the Procedure is less than a decade old and there is limited information available regarding the long-term safety and effectiveness.

12. I understand that the Procedure does not correct certain vision problems, including but not limited to amblyopia, strabismus, presbyopia, and cataracts.

13. I understand that the field of refractive surgery is continuing to evolve and that if I were to postpone my surgery there is the possibility that the LASIK and/or PRK procedure might be improved or some other procedure might become available.

14. I understand that my surgeon is a medical doctor and a board certified ophthalmologist and ophthalmic surgeon who is experienced with LASIK and/or PRK and has been credentialed to meet the standards required for certification by Coal Harbour Eye Centre.

15. I understand that I will need certain post-operative care. The day after my surgery I will return to the Centre for a post-operative visit, which will include an examination by an eye care professional. An

optometrist or other eye care professional at the Centre will provide additional post-operative care, with referral back to my optometrist or surgeon if indicated. Post-operative care (24 hour, one week, one month, and three month) at the Centre (except for the cost of glasses, plugs, contact lenses or the cost of certain medications) is included in my fee. I understand that if I so desire, I may make other arrangements for post-operative care at my own expense. If this is my choice, I confirm that I have made arrangements to have my post-operative care provided by____ M.D., who is an optometrist/ ophthalmologist (circle one) located in ____________________________________ has agreed to provide my post-operative care.

16. Steven Kirzner MD, is the major owner and operator of this centre. Other surgeons and optometrists or agents of the Centre are not owners and are independent professionals who are responsible directly to me for their acts and omissions.

17. I have had the opportunity to ask questions about the Procedure and all of my questions have been answered satisfactorily. (Any further questions will be answered by my surgeon.)

18. I give my surgeon, my optometrist and Coal Harbour Eye Centre permission to use data about my treatment for research purposes. I understand that my name and personal identifying information will remain confidential, unless I give written permission for the disclosure of such information. (Patient may delete this clause if choose not to participate in research activities).

19. I give my surgeon and Coal Harbour Eye Centre permission to videotape or photograph the Procedure. (Patient may decline to be video taped and may delete this clause)

20. I understand that the applicable governing law for this procedure is the law of British Columbia.

21. If my surgeon, _________________________________ M.D. has advised me that I have a higher possibility of complications or risks arising from the procedure because I have certain medical conditions or risk factors, I understand that I am required to complete separate consent forms, which address my condition and/or risk factors.

22. I am not under the influence of any sedative. I am of clear mind and understand the nature of the Procedure and the possible risks related to the Procedure. I will be given a sedative after signing this consent (the patient may refuse sedative, but this is generally not advised).

PATIENT CONSENT SIGNATURES

I understand that by signing below, I am indicating that I have read and understood the information in this Patient Consent Form, that I have been verbally advised about the Procedure, that I have had an opportunity to

ask questions, that I have received all of the information I desire concerning the Procedure, and that I authorize and consent to the performance of the Procedure and any different or further procedures which in the opinion of my surgeon are necessary due to an emergency. I understand that I have been fully informed and give informed consent. (Patient may elect to talk to surgeon first.)

Patient's Name (please print): ____________________________________

Patient's Signature: ____________________________________

Surgeon's (Witness) Name (please print): ________________________________

Surgeon's (Witness) Signature: ____________________________________

Date: ______________________________ Time: ________________________

Patient Address: ____

____

Patient Telephone Number (Day): ___________________________________

Date of Birth: ____

GOVERNING LAW

The patient (by name) agrees that the relationship between himself/herself and the performing surgeon at Dr. Steven Kirzner's clinic shall be governed and construed in accordance with the laws of the Province of British Columbia.

JURISDICTION

The patient acknowledges that the treatment/service was performed in the Province of British Columbia and that the Courts of the Province of British Columbia shall have jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. The patient hereby agrees that he/she will commence any such legal proceedings in the Province of British Columbia and only in the Province of British Columbia and hereby submits to the jurisdiction of the Courts of the Province of British Columbia.

Patient Signature: ____

Patient Name: ____

Date: ____

Time: ____

Place (city): **Vancouver, British Columbia**

Witness Signature: ____

Witness Name: ____

CERTIFICATION BY SURGEON

I, ____ MD, hereby certify that:

1. I have been introduced to the patient, and the patient understands that I will be performing the surgery.

2. The patient understands the procedure and has no further questions.

3. The Patient is a suitable candidate for LASIK or PRK (please circle one) given the ophthalmic findings and the Patient's physical, social, emotional and/or occupational needs.

4. I have discussed any special circumstances with the Patient and the additional potential risks posed by those special circumstances, including the following:

(TO BE COMPLETED BY SURGEON)

____

5. Arrangements have been discussed with the patient who has agreed to plan for post-operative care.

____

6. Patient understands that there is a 1 in 2500 chance of aborting surgery due to Flap complications and may or may not consider further surgery in the future should this occur.

7. Patient understands majority of Flap complications can be corrected through further Lasik or PRK procedures.

8. Patient has no further questions and understands informed consent.

9. I have ascertained that the Patient fully understands the answers to questions that he/she posed to me.

10. The Patient fully understands the risks, benefits and possible alternatives to the Procedure.

Name of Surgeon: ____

Signature: ____

Date: ____