Consent for Oculoplastic Surgery

I, _____, authorize Tamara Fountain, M.D to perform the following surgery(ies):

_____

_____

_____

I understand that surgery may involve shots near the eye to numb the area and risks of these shots include:

> perforation of the eyeball, damage to optic nerve or retina, difficulty breathing or loss of blood pressure, and loss of vision.

The nature and purpose of the surgical procedure, alternatives and risks have been explained to me by Dr. Fountain. I understand that observation (no surgery) is an alternative in most cases but I am choosing to undergo a surgical procedure. I acknowledge that no guarantee or assurance has been made as to the final result. I understand the following complications could occur:

> Loss of vision, double vision, bleeding, infection, development or worsening of tearing and dry eyes, inability to wear contact lenses comfortably, numbness, eyelid malposition or asymmetry, failure to solve or possible aggravation of problem, need for additional surgery or other treatment.

I hereby acknowledge that I understand and agree to the above and have had all my questions answered.

Patient_____ Date_____

Witness_____