Consent Form: INTRA-VITREAL INJECTION

Retina and choroid diseases, which cause deterioration in sharpness of vision, quality of vision, and field of vision, due to the growth of pathological blood vessels in the eye, and leaks from blood vessels in the choroid and retina, have been treated in recent years by intra-vitreal injections of anti-VEGF (Vascular Endothelial Growth Factor) protein products.

The main indications in which intra-vitreal injections are used are: growth of choroid blood vessels due to molecular atrophy or other diseases, retinopathy due to diabetes, retinal vein occlusions, and retinal edemas. In addition, it is possible to inject steroids into the vitreous fluid as treatment for retinal edema and Uveitis.

The treatment is administered using local anesthetics, frequency adapted to the patient's disease and reaction to treatment. In most cases, repeat injections are necessary as often as once a month for an unlimited time.

Patient's name:

Last name **First name** **Father's name** **I.D.**

I hereby declare and confirm having received a detailed oral explanation from Dr. _____
Last name First name

regarding the need to inject the **left eye** vitreous humor (note name of drug(s)): Avastin / Lucentis / Eylea / Ozurdex / other _____

The **right eye** (note name of drug(s)): Avastin / Lucentis / Eylea / Ozurdex / other _____
_____

Due to: wet Molecular Athropy (AMD) / molecular edema / Uveitis / other (specify) _____
_____

I hereby declare and confirm that the treatment alternatives optional for me under the circumstances have been explained to me, including: other preparations, photodynamic treatment, and laser treatment. The chances for improvement, side effects, and risks involved in each one of these procedures were explained to me. It was made clear to me that the intra-vitreal injection of Avastin, should it be made, is provided off label and its long-term effects are unknown.

I hereby declare and confirm that the possible side effects of injecting the medication into the vitreous fluid have been explained to me, including: ocular pains, subconjunctival hemorrhage, black dots within the field of vision, edema or irregularity of the cornea surface, Uveitis, vision impairments, sensitivity to the injected drug and/or disinfectant and/or antibiotics provided as part of the treatment. In most cases these side effects clear on their own or react to treatment, but often times it may take longer to achieve full recovery.

In addition, the possible complications were explained to me, including: retinal detachment, the formation of cataract, increase of intraocular pressure, intra-vitreal hemorrhaging, and intra-vitreal bacterial infection (Endophthalmitis). In most cases these complications can be treated using drugs or further surgery, but in some cases these complications may even cause a complete loss of vision and a shrinking of the eye.

I hereby give my consent to conduct the Main Procedure, including the planned series of injections.

I hereby declare and confirm that it was explained to me and that I understand that there is an option that during the Main Procedure it would become evident that its scope must be expanded, changed, or that other procedures may need to be taken so as to save the eye or prevent bodily harm, including surgical actions which cannot be anticipated with certainty or fully at the moment, but their meaning has been made clear to me. Therefore, I agree to the aforementioned expansion, change, or performance of other or additional procedures, including surgical actions which in the doctor's opinion may be vital or necessary during the main procedure. My consent is also given for the performance of local anesthetics, having been explained the risks and complications of local anesthetics, using drops, including: sensitivity, reddening, and discomfort.

I am aware of and consent to having the main procedure and all other procedures conducted by whomever may be charged with doing so, in accordance with the procedures and instructions of the institute and I was not promised that they would all or part thereof be conducted by a certain person, so long as they are done with the customary warranty established in the hospital or ambulant medical institution and as stipulated by current legislation.

05/12/2021		
Date	**Time of signing**	**Patient's signature**

Guardian's name (relation)	**Guardian's signature (in cases of an incompetent, minor, or mentally ill person)**

I hereby confirm that I have orally explained to the patient / the patient's guardian* all of the above with the necessary specifications and that she/he have signed this consent before me having been convinced that she/he understood my explanations in full.

Doctor's name	**Doctor's signature**	**License number**

* Delete the unnecessary