Acadiana Retina Consultants
CONSENT FOR MEDICAL PROCEDURE AND
ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent to your contemplated surgery or medical procedure. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of your contemplated operation or medical procedure and the risks associated with it and that we have answered all of your questions in a satisfactory manner. Please read the form carefully. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct Dr. Frank Culotta with associates or assistants of his choice to perform upon myself, John Doe1234, the following surgical, diagnostic, or medical procedure:

Pars plana vitrectomy, gas/fluid exchange, laser, epi-retinal membrane peel, retinal cryopexy

to the Right Eye for the diagnosis of Retinal Detachment with Single Break OD

including any necessary or advisable anesthesia. I further authorize the doctors to perform any other procedure that in their judgement is advisable for my well being. This operation has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each as well as the risk of no surgery. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the medical procedure or as to cure.

In general terms, the nature and purpose of this operation or medical procedure is to attempt to repair/treat the condition and complications presented by Retinal Detachment with Single Break OD.

Some risks known to be associated with this procedure, including anesthesia, are:

Brain Damage	Disfiguring Scars	**Need for additional treatment and/or surgery**
Quadriplegia (Paralysis of all arms and legs)	**Death**	**Double vision**
Paraplegia (Paralysis of both legs)	**Loss of vision**	**Cataract Formation**
Loss of Organ	**Loss of eye**	**Retinal Detachment**
Loss of Arm or Leg	**Infection**	
Loss of Function of Organ	**Bleeding**	
Loss of Function of Arm or Leg	Uncomfortable or painful eye	

I have been informed of the probability of occurrence of each of the foregoing risks as the result of or in connection with the surgical or medical procedure contemplated herein.

I hereby authorize and direct the above named physician with associates or assistants to provide such additional services as they may deem reasonable and necessary including, but not limited to, the administration of any anesthetic agent, or services of the X-ray department or laboratories, and I hereby consent thereto.

I hereby state that I have read and understand this consent, all questions about the procedure or procedures have been answered in a satisfactory manner, and that all blanks were filled in prior to my signature. This consent form is valid until revoked by me in writing.

Signature of Patient: _____Date: _____Time:_____am./p.m.

Signature of Relative: _____
(Where Required)

Signature of Representative: _____
(Where Required)

Witness: _____

I certify that all blanks in this form were filled in prior to signature and I explained them to the patient or his representative before requesting the patient or his representative to sign it.

Signature of Physician: **Electronically signed by Dr. Frank Culotta at 7/21/2019, 2:38:31 PM**

Acadiana Retina Consultants, LLC
1101 S. College Rd., Suite 304 Lafayette, LA 70503
Ph.: 337-232-2710 Fax: 337-232-6824

Surgery Scheduling Sheet

Surgeon: Dr. Frank Culotta
Surgery Date:
Patient Name: John Doe1234
Date of Birth: 2/2/1929
Chart # 1234TESTJOHN
Posted By: _____
Authorization:

_____

- Insurance
- Self-Pay: Doctor/'s Fee $_____ Deposit: _____Paid: $_____

Facility: Surgery Center
Procedure: Pars plana vitrectomy, gas/fluid exchange, laser, epi-retinal membrane peel, retinal cryopexy
Eye: **Right Eye**
Anesthesia: local/MAC
Admit Type: OP
Post Procedure: Phase II Extended Recovery

Procedure CPT Code: 67108
Diagnosis Pre-Op/ICD9 Code: Retinal Detachment with Single Break OD (H33.011)

Diagnosis Post-Op:_____

Patient Position Post-Op:_____

Procedures:

_____

_____

Case Comments: _____

Gave RX:___ Gave Labs:____ Initials:____ Pt Dr:_____

FRANK J. CULOTTA, JR., M.D.
SCOTT T. GAUTHREAUX, M.D.
OPHTHALMOLOGY
PRACTICE LIMITED TO DISEASES AND SURGERY
OF THE RETINA, MACULA, AND VITREOUS

1101 SOUTH COLLEGE RD.
SUITE 304
LAFAYETTE, LA 70503

PHONE: 337-232-2710
FAX: 337-232-6824

MEDICAL CLEARANCE FOR SURGERY/ANESTHESIA

Patient: John Doe1234 Date of Birth: 2/2/1929

Surgeon: Dr. Frank Culotta DOS:

Proposed Surgical Procedure: Pars plana vitrectomy, gas/fluid exchange, laser, epi-retinal membrane peel, retinal cryopexy

Planned Anesthesia:

local/MAC

Labs/Test/Diagnostic Orders- See Attached

****The following is to be completed by the Examining Physician****

Patient is cleared for proposed surgical procedure and anesthesia in ambulatory surgical center

- YES
- NO

Recommendations/Comments:

_____

_____

Directions for Anticoagulants:

_____

_____

_____ _____

Examining Physician/'s Signature Date

_____

Examining Physician/'s Name (please print)

Please fax completed form to our office at 337-232-6824 ASAP for further processing

PRE-OPERATIVE ORDERS
FOR SURGERY CLEARANCE

PATIENT: John Doe1234 Date of Birth: 2/2/1929 DOS:

DIAGNOSIS: DATE: 7/21/2019

BMP. EKG.

(If pt has recent labs/EKG from within 6 months, no new testing is required)

Electronically signed by Dr. Frank Culotta at 7/21/2019, 2:38:27 PM

Please fax results to Surgery Center, Inc. @ 337-234-0341 and physician/'s office @ 337-232-6824

Dr. Frank Culotta
1101 S. College Road
Lafayette, LA 70503
337-232-2710

Patient Name: John Doe1234 **Date:** 7/21/2019
Date of Birth: 2/2/1929

Rx

Durezol Ophthalmic Suspension 0.05%
1 Bottle
1 drop 4 times/day in Right Eye

Refills:0

Besivance Ophthalmic Suspension 0.6%
1 Bottle
1 drop 4 times/day in Right Eye

Refills:0

Electronically signed by Dr. Frank Culotta at 7/21/2019, 2:38:27 PM

Instructions

You have been given 3 pages from our office. These pages contain your prescription for the drops you will need to use after the surgery, an order for pre-operative lab work, and a medical clearance form.

You will need to have the prescription filled at the pharmacy of your choice before the day of surgery. Please have those drops ready at the Surgery Center on the day of the procedure so we can verify that you have the correct medication.

The pre-operative lab work and medical clearance form can be brought to your primary doctor's office and they can fill out the clearance form as well as organize any lab work that needs to be done. All of our fax/communication information is present on the forms you have been given so the lab/doctor office can simply fax them back when they are completed.

Any questions are complications should be communicated with our office immediately as the delay of obtaining these requirements can delay the procedure you are intending to have.