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Informed Consent For Corneal Collagen Cross Link

Patient Name	:	Reshma Siya				Emirates ID	:	784-6478-3648736-8
File No	:	4	DOB	:	1995-05-21	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	Opthalmology Doctor	Date	:	2024-02-16

I, the undersignee Reshma Siya with file number 4, acknowledge that I have been informed with the following:

- Corneal Collagen Cross Linking is not a form of refractive surgery and there is a possibility that I may need glasses or contact lenses after the procedure.
- As with all types of surgery there is a risk of complications which include but are not limited to glare, a star bursting or halo effect, especially while driving at night.

By signing this informed consent, I certify that I have read the preceding information and understand the content. The details of the procedure have been presented and explained to me by my Ophthalmologist. My Ophthalmologist has answered all my questions to my satisfaction and has discussed the risks, benefits, and alternatives of the procedure.

Hereby, I authorize my Doctor to perform Corneal Collagen Cross Linking procedure on my eye/s under local anesthesia:

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	Witness	Doctor
		
Patient Name Reshma Siya Date 2024-02-16	Witness Name bvbvcb Date 2024-02-16	Doctor Name Opthalmology Doctor - Ophthalmology (Oph45) Date 2024-02-16

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