

Informed Consent For Lasik/Lasek Procedure



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

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

- I may not get a full correction from my procedure and this may require further retreatment procedures.
- I might develop glare, a star bursting or halo effect, especially while driving at night.
- Keratoconus (Post Lasik Ectasia) is a possible complication which might necessitate Corneal Collagen Cross Linking in the future.

By signing this informed consent form, 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 the Lasik/Lasek 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
		<div style="border: 1px solid black; width: 100px; height: 70px; margin: 0 auto;"></div>
Patient Name Reshma Siya Date 2024-02-16	Witness Name dsvv Date 2024-02-16	Doctor Name Ophthalmology Doctor - Ophthalmology (Oph45) Date 2024-02-16