Informed Consent For Enhancement Procedure

Patient Name	:	sai krishna				Emirates ID	:	784-8666-6666666-7
File No	:	8	DOB	:	1996-09-25	Nationality	:	Other
Gender	:	Male	Doctor's Name	:	Opthalmology Doctor	Date	:	2024-02-27

I, the undersignee sai krishna with file number 8, acknowledge that I have been informed with the following:

- Retreatment are at times indicated to correct remaining or induced myopia (nearsightedness), hyperopia (farsightedness), and astigmatism. There is no guarantee that repeat Lasik will correct the problem. Alternative forms of vision correction exist including eyeglasses, contact lenses and others.
- Repeat Lasik may result in overcorrection and under correction leaving patients nearsighted, farsighted, or with astigmatism.
- I might develop glare, a star bursting or halo effect around light, especially at night.
- I might develop epithelial ingrowth which is a complication produced when epithelial surface cells grow underneath the corneal flap during the healing of the corneal flap incision.
- I might develop Keratoconus (Post Lasik Ectasia) which might necessitate corneal 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 Enhancement procedure on my g eye/s under local anesthesia:

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	Witness	Doctor
		
Patient Name sai krishna Date 2024-02-27	Witness Name g Date 2024-02-27	Doctor Name Opthalmology Doctor - Ophthalmology (Oph45) Date 2024-02-27

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