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Consent for Oculoplastic Surgery

I, _____, authorize Tamara R. Fountain, M.D., to perform the following surgery(ies):

_____

_____

_____

I understand that surgery may involve shots near the eye to numb the area and risks of these shots include:

perforation of the eyeball, damage to optic nerve or retina, difficulty breathing or loss of blood pressure, and loss of vision.

The nature and purpose of the surgical procedure, alternatives and risks have been explained to me by Dr. Fountain. I acknowledge that no guarantee or assurance has been made as to the final result. I understand the following complications could occur weeks, months or even years later:

Loss of vision, double vision, bleeding, infection, development or worsening of tearing and dry eyes, numbness, eyelid malposition or asymmetry, failure to solve or possible aggravation of problem, need for additional surgery or other treatment _____

_____

**********I have had all my questions answered. I hereby acknowledge that I understand and agree to the above.

Patient_____ Date_____

Witness_____