Sabre Springs
OPTOMETRY
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Informed Consent for Contact Lenses

Your contact lens: _____
Wearing schedule:_____10-12 hours, Do NOT sleep in contacts lenses_____
Replacement schedule:_____Daily_____2Weeks_____1 Month___
Cleaning/Disinfection solution:____BioTrue_____OptiFree Pure Moist___

The purpose of this informed consent form is:

• to choose to wear contact lenses and to accept the risks of complications
• to satisfy yourself that you fully understand possible complications and their consequences
• to ensure that you have obtained satisfactory answers to any questions relating to this agreement or any details of what contact lens wear involves
• to follow all instructions provided by the practitioner including all follow-up visits scheduled by your optometrist

Possible Complications of improper contact lens care:

• discomfort and/or pain
• temporary or permanent loss of vision
• swelling or inflammation of the cornea
• small blood vessels growing into the cornea
• formation of small bumps under the eyelids
• accumulation of debris or mucus on or behind the lens, which may reduce vision and/or comfort with the lens
• internal inflammation of the eye
• abrasions of the front surface of the eye
• infection with potentially harmful microorganisms (microbial keratitis)

Alternate Vision Correction:

• Spectacle lenses –sunglasses, clear, or multifocal lenses. Spectacle wear eliminate the risk factors associated of contact lenses.
• Daily disposable lenses – Available in a wide range of corrective powers including astigmatic prescription. Offers the convenience of easy use and is much healthier than sleeping in lenses.
• Refractive surgery – Though not all patients will be good candidates, for many, refractive surgery is a good option for establishing good distance vision without having to sleep in contact lenses. Refractive surgery carries its own risks.

I certify that I have read the preceding information and understood the contents. Basic procedures of lens care, alternative vision correction, cleaning and disinfection methods and the advantages and disadvantages of extended wear have been explained to me by my optometrist. My optometrist has also answered any questions I have concerning the consent form. Although it is impossible for my optometrist to inform me of every possible complication, my questions have been answered to my satisfaction. I fully understand the risks, complications and benefits that may be derived from contact lens wear. Should any complications or emergencies occur, I agree to contact my optometrist immediately at the contact numbers provided. I also agree to wear the lenses in such a way as is prescribed and am willing to follow the advice of my optometrist and the information that has been provided to me. My decision to wear contact lenses has been voluntarily and freely made.

_____	_____	_____
Patient full name	Patient signature	Date
_____	_____	_____
Parent/Guardian	Parent/Guardian signature	Date