BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Orbital Floor Reconstruction

This information is given to you so that you can make an informed decision about having **Orbital Floor Reconstruction.**

Reason and Purpose of the Procedure:

The orbital floor is made up of bones around your eye. Reconstruction of the orbital floor is done to improve the position and/or movement of the eyeball damaged by a fracture.

Benefits of this surgery:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Improve position of the eyeball.
- Improve double vision symptoms.
- Improve eye movement.

Risks of Surgery:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General risks of surgery:

- **Small areas of the lungs may collapse**. This would increase the risk of infection. This may need antibiotics and breathing treatments.
- **Blood clots may form** in the legs, with pain and swelling. These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- A **strain on the heart or a stroke** may occur.
- **Bleeding may occur**. You may need a transfusion.
- **Reaction to the anesthetic may occur.** The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you. **This procedure is always done under a general anesthesia.**

Risks of this surgery:

- **Infection**: May need more antibiotics, drainage and hardware removal.
- **Double Vision/Blindness**: Injury to the eye and surrounding structures is possible. Double vision may not improve. Glasses or more procedures may be needed.
- **Eyeball malposition**: The eye may stick out or sink in more than before injury or surgery.
- **Eyelid malposition**: Incisions in the eyelid may leave scars. They may change the position and function of the lid.
- **Numbness/weakness**: Injury or surgery may cause skin numbness and muscle weakness. This may be permanent.
- **Pain**: Lasting pain is rare.
- **Hardware**: Small screws, plates and stitches may be noticeable. Hardware may need to be removed at a later surgery.

Risks specific to you:

_____

_____

_____

_____

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Obesity, Diabetes, and Smoking are linked to an increased risk of infections. They can also lead to heart and lung complications and blood clot formation.

Alternative Treatments:

Other choices:

- Do nothing. You can decide not to have the procedure.

If you choose not to have this treatment:

- Eyeball position and movement may not improve.
- Vision problems may not improve.

General Information

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure the doctor may need to do more tests or treatment.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

I agree to release my social security number, my name and address, and my date of birth to the company that makes the medical device that is put in or removed during this procedure. Federal laws and rules require this. The company will use this information to locate me.

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By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Orbital Floor Reconstruction** _____

  _____
- I understand that my doctor may ask a partner to do the surgery.
- I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. If so, please obtain consent for blood/products.

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Closest relative (relationship) _____ ☐ Guardian/POA Healthcare

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back:

Patient shows understanding by stating in his or her own words:

_____ Reason(s) for the treatment/procedure: _____
_____ Area(s) of the body that will be affected: _____
_____ Benefit(s) of the procedure: _____
_____ Risk(s) of the procedure: _____
_____ Alternative(s) to the procedure: _____

OR

_____ Patient elects not to proceed: _____ Date: _____ Time: _____
(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____