JUSTIN A. SAUNDERS, M.D.

DOCTORS PARK, SUITE 101
1517 NICHOLASVILLE ROAD
LEXINGTON, KENTUCKY 40503
TEL (859) 277-4403
FAX (859) 277-4405

JOSEPH H. SAUNDERS, M.D.
(DECEASED)

JUSTIN A. SAUNDERS, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
OF EYELIDS, TEAR DUCTS AND ORBIT
www.justinsaundersmd.com

JOHN H. SAUNDERS, M.D.
(RETIRED)

Patient Name:

Date of Birth:

Diagnosis: Exposure Keratopathy, Right Eye Left Eye

Procedure: Tarsorrhaphy, Right Eye Left Eye

1. In conjunction with the procedure identified above, I understand the following:

   a. Nature and purpose of procedure (Describe in laymen's terms): **Suture eye closed to help protect eye and promote healing**

   b. Material risks of procedure: DEATH, CARDIAC ARREST, BRAIN DAMAGE, DISFIGURING SCAR, PARAPLEGIA OR QUADRIPLEGIA, PARALYSIS OR PARTIAL PARALYSIS, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, SEVERE LOSS OF BLOOD, ALLERGIC REACTION, INFECTION, LOSS OF VISION, DOUBLE VISION, NEED FOR FURTHER SURGERY.

   c. Likelihood of success: _X_ Good __ Fair __ Poor

   d. Practical alternatives to procedure: __ None _X_ Other: frequent lubrication

   e. Prognosis if procedure rejected: __ Good __ Fair __ Poor
   _X_ Unknown because: potential for spontaneous improvement or worsening of condition leading to permanent scarring, infection, loss of vision or loss of eye

2. **Consent:** The procedure identified above has been explained to me and all of my questions have been answered. I acknowledge that no guarantees have been made concerning the outcome of the procedure. I hereby consent to the performance of this procedure by Dr. Justin Saunders.

3. I realize that, during the procedure, the physician may become aware of conditions which were not apparent before the start of the procedure. I therefore consent to any additional or different operations or procedures the physician considers necessary or appropriate to treat, cure or diagnose such conditions.

_____
Signature of Physician

_____
Patient Signature/Authorized Person

_____
Date