MINOR PROCEDURE CONSENT & TREATMENT

Date: ___________________________________
Name:___________________________________
Preoperative Diagnosis: _______________________________________________________
Postoperative Diagnosis: ______________________________________________________
Procedure: __________________________________________________________________ 
Topical Anesthesia: Medication_________________________ Amount _____________ Site ___________
Complications: _______________________________________________________________
Indication(s):

Consent:
I hereby authorize ______________________ to perform the indicated procedure on my RIGHT LEFT BOTH
eye(s). The procedure, alternatives, risks and possible complications have been explained to me and I understand
them. I acknowledge that no guarantee or assurance has been given to me as to the results that may be obtained.

Signature:_____________________________________Date:_____________________
Witness:______________________________________Time:_____________________

Description of procedure:

The patient tolerated the procedure well and left in good condition. The postoperative instructions were given
including the medications and activity level as well as a follow-up appointment.

Signature _____________________________________