ADVANCED VISION CARE

Dilation Consent Form

Date: _____

Patient Name: _____

Guardian Name (If Applicable): _____

Dear Patient,

During your initial visit to our office and/or subsequent visits, your doctor may be dilating the pupils of your eyes. The purpose of this procedure is to get a more complete look into the back of your eye to detect and monitor many diseases including glaucoma, macular degeneration, cataracts, and more. Dilation of the pupil has been mandated by the State of Florida for all new patients and when medically necessary. In some cases, the dilation may be used to aid your doctor in prescribing glasses, especially for children.

The dilation procedure involves the doctor placing some drops on the front surface of the eye. In most cases, there is a temporary stinging sensation that lasts several seconds. The drops will in most cases cause blurry vision for approximately 4 hours or more, as well sensitivity to light during that time. The blurry vision may impair your ability to function at certain tasks such as driving, handling machinery, computer work, etc. It is recommended that you wear UV protection for your eyes outdoors after having your eye dilated as a dilated eye is at greater risk to UV exposure.

Please sign below acknowledging your desire or refusal to have your eyes dilated.

___ I refuse to have my (or _____) eyes dilated today. I understand that the doctor will be limited in his or her ability to fully evaluate the back of your eye.

___ I consent to have my (or _____) eyes dilated today.

Patient or Guardian Signature: _____ Date: _____