



## Consent to Treatment

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to perform the proposed procedure(s) described below (including all preliminary and related procedures, and any additional or alternative procedures as may become medically necessary during the course of the diagnostic procedure and/or treatment).

I understand that the Kensington Eye Institute is a teaching institute. I therefore give consent for supervised health practitioners-in-training to participate in my care. I further agree that at his/her discretion, my physician (or other health practitioner) may call upon the assistance of other institute staff as appropriate, and may allow them to order or perform all or part of the diagnostic procedure(s) and/or treatment(s) and they shall have the same discretion in my investigation/treatment as my health practitioner.

I understand that my surgery may be videotaped for educational purposes and give permission for obtaining the video and using the video as needed by my surgery.

I do not give permission to be videotaped during my surgery.

I confirm that the nature of the treatment(s), expected benefits, material side effects, material risks, special or unusual risks, alternative courses of action, as well as the consequences of not having the treatment, have been explained to me by \_\_\_\_\_ in a manner that I understand.  
(Health Practitioner)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Substitute Decision Maker

If Substitute Decision Maker, state relationship (and complete Identification of Substitute Decision Maker form).

\_\_\_\_\_  
Name of Interpreter (please print)

\_\_\_\_\_  
Signature of Interpreter

### TO BE COMPLETED BY PHYSICIAN/HEALTH PRACTITIONER

**(N.B. Failure to complete this portion of the consent form may result in the withholding of treatment to this patient.)**

I confirm that I have explained the nature of the treatment(s), expected benefits, material side effects, the material risks, special or unusual risks, alternative courses of action as well as the likely consequences of not having the treatment and answered all questions.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Health Practitioner



**PRE-OPERATIVE PATIENT  
QUESTIONNAIRE**

Patient's Name: \_\_\_\_\_

Surgeon's Name: \_\_\_\_\_

Surgery Date: \_\_\_\_\_

Do you have high blood pressure?  Yes  No  Not Sure

Do you feel short of breath when lying flat?  Yes  No

Have you had any heart tests other than ECG in the last 2 years?  Yes  No  Not Sure

Can you do the following at a normal pace without stopping? Walk 1 block  Yes  No

Climb 1 flight of stairs  Yes  No

Cardiologist's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**PREVIOUS HOSPITALIZATIONS**

Have you been admitted to a hospital in Canada or abroad in the past 2 years?  Yes  No

**LIST ALL SURGERIES YOU HAVE HAD**

Procedure	Hospital	Year

**ANESTHETIC HISTORY**

Have you ever had general anesthesia?  Yes  No

Have you ever had regional anesthesia? (eg. nerve block, epidural or spinal)  Yes  No

Have you been told by a doctor that you have had problems with an anesthetic?

Difficult Intubation  Malignant Hyperthermia  Confusion after surgery

Has anyone in your family ever had any serious problems with an anesthetic?  Yes  No  Not Sure

Do you have any trouble opening your mouth or moving your neck?  Yes  No  Not Sure

**MEDICAL HISTORY (SELECT ALL THAT APPLY)**

**REPIRATORY HEALTH**

Asthma  Chronic Obstructive Pulmonary Disease (COPD)  Tuberculosis

Tracheostomy  Other (Please specify): \_\_\_\_\_

Do you use oxygen at home to help you breathe?  Yes  No  Not Sure

Have you seen a respirologist in the past 2 years?  Yes  No

**ENDOCRINE AND METABOLIC HEALTH**

Do you have diabetes?  Yes  No Are you on?  Insulin  Diabetic pills  Diet only

Do you have thyroid problems?  Yes  No  Not Sure

Other: \_\_\_\_\_

**PRE-OPERATIVE PATIENT  
QUESTIONNAIRE**

Patient's Name: \_\_\_\_\_

Surgeon's Name: \_\_\_\_\_

Surgery Date: \_\_\_\_\_

**KIDNEY AND BLADDER HEALTH**

Do you have kidney disease?  Yes  No  Not Sure

Are you on dialysis?  Yes  No  Not Sure

Have you seen a nephrologist in the past 2 years?  Yes  No  Not Sure

Nephrologist's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**BLOOD HEALTH**

A diagnosed blood disorder

Hepatitis

Sickle cell trait

Anemia (low blood count)

Sickle cell anemia

A blood clot (in lungs, legs, or elsewhere)

HIV/AIDS

Other (Please specify): \_\_\_\_\_

Have you received blood or blood products in the last 3 months?  Yes  No  Not Sure

Haematologist's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**NERVE, MUSCLE AND BONE HEALTH**

Have you ever been diagnosed with:

A disease that affects your muscles/nerves

A stroke or stroke-like symptoms

A brain aneurysm

Spinal cord problems (e.g. spinal stenosis)

Fibromyalgia

Dementia

A seizure disorder (e.g. spinal epilepsy)

Dementia

Unable to lie flat

Fainting spells, vertigo in the past 2 years

Neuropathy

Alzheimer's Disease

Osteoarthritis

Migraines

Ankylosing spondylitis

Rheumatoid arthritis

Other (Please specify): \_\_\_\_\_

**MEDICAL HISTORY (SELECT ALL THAT APPLY)**

**STOMACH AND INTESTINAL HEALTH**

Feeding tube

Heartburn/reflux

Hiatus hernia (stomach)

Liver disease

Inflammatory bowel disease

Other: \_\_\_\_\_

Do you have difficulty eating or swallowing?  Yes  No

Do you have any nausea, vomiting, choking?  Yes  No

**PRE-OPERATIVE PATIENT  
QUESTIONNAIRE**

Patient's Name: \_\_\_\_\_

Surgeon's Name: \_\_\_\_\_

Surgery Date: \_\_\_\_\_

**OTHER IMPORTANT MEDICAL INFORMATION**

Do you use any street drugs?  Yes  No

If yes, please list: \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink alcohol?  Yes  No

If yes, how much: \_\_\_\_\_ How often? \_\_\_\_\_

Is there a possibility that you could be pregnant?  Yes  No

Have you ever had cancer?  Yes  No

When: \_\_\_\_\_ Type: \_\_\_\_\_

Chemotherapy/Radiation?  Yes  No

Do you smoke cigarettes?  Yes  No If yes, how often? \_\_\_\_\_

Do you smoke or consume cannabis?  Yes  No If yes, how often? \_\_\_\_\_

Have you had problems with your mental health?  Yes  No

If yes, please specify: \_\_\_\_\_

Do you have any hearing impairments?  Yes  No

Do you have any mobility limitations?  Yes  No

Do you have claustrophobia?  Yes  No

Please tell us about any other illnesses, limitations or concerns we should know about:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Health History Questionnaire completed by:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

## KENSINGTON EYE INSTITUTE: PRE-OPERATIVE PATIENT INSTRUCTIONS

\*to be filled out by the surgeon's office\*

SURGERY DATE: \_\_\_\_\_

ARRIVAL TIME: \_\_\_\_\_ SURGERY TIME: \_\_\_\_\_

Please note that the building opens at 7:00 a.m. Our clinic closes at 4:00 p.m.

**\*YOUR SURGERY IS SCHEDULED BY YOUR SURGEON'S OFFICE, NOT BY THE KENSINGTON EYE INSTITUTE. PLEASE CONTACT YOUR SURGEON'S OFFICE IF YOU WISH TO CONFIRM YOUR ARRIVAL AND SURGERY TIME. FOR SURGEON CONTACT LIST, VISIT:**

**[www.kensingtonhealth.org/eye-surgery/about-us/surgeons](http://www.kensingtonhealth.org/eye-surgery/about-us/surgeons)**

**\*PLEASE CONFIRM YOUR PRE-AND POST-OPERATIVE EYE DROPS WITH YOUR SURGEON.**

### FOOD & DRINK



- Please **do not** consume solid foods or have anything to drink **after midnight**. However you may have water, black tea or coffee **WITHOUT** any milk, cream, sugar or artificial sweeteners, 3hrs before your surgery time.
- Please **do not** consume soup or broth of any kind.
- Please **do not** chew gum (this includes sugar-free gum) or consume candies, mints or cough drops.

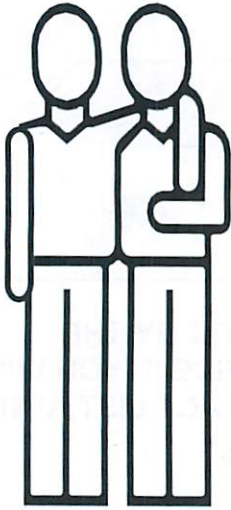
### MEDICATION INSTRUCTIONS



- Take your morning medication (**but do not take diabetic pills**) with clear fluids three hours before coming to the clinic.
- Please **do not take insulin on the morning of your surgery** but bring your insulin with you to the clinic.
- Please bring all of your prescription medication with you, in their original bottles.

**\*IF YOU DO NOT FOLLOW THESE INSTRUCTIONS, YOUR SURGERY MAY BE CANCELLED.**

## IMPORTANT REMINDERS



- Please arrange for a responsible adult or teenager(14+) to pick you up from your procedure. Please note: Taxi services or wheel-trans are not considered accompaniment home and you will not be released.
- The person picking you up **will not be allowed to accompany you into the waiting room** unless they are a translator, or if you have a disability (physical/cognitive) and they are aiding you. Only **one person** acting as a translator/aide is allowed to come upstairs with patient.
- The aide/translator must wait elsewhere once while the patient is undergoing their procedure.
- Please provide us with the name and telephone number of the person picking you up. We will call them **after** your procedure has finished and ask them to come up to the pick-up area.

## PREPARING FOR YOUR APPOINTMENT

- Bring your OHIP (health) card to every visit.
- Wear loose fitting clothing that opens in the front.
- Please do not wear multiple layers of clothing, full slips or dresses.
- Please do not wear eye makeup, jewelry, perfume or cologne.
- Unexpected complications and cancellations on the day of surgery may delay or advance your surgery time.
- It is not advisable to book any other appointments on the day of surgery.

## PARKING

- Free 1-hour parking is available on Brunswick Ave. and Major St.
- Paid parking is available through IMPARK on 340 College St., accessed via Brunswick Ave.
- Visit [www.kensingtonhealth.org/contact-us](http://www.kensingtonhealth.org/contact-us) to view daily parking rates.
- You can pay for parking with a credit card or coins. To register your vehicle, enter your license plate number at the pay station, and take the ticket with you.

## CATARACT SURGERY: POST-OPERATIVE INSTRUCTIONS

\*to be filled out by care team\*

### FOLLOW UP APPOINTMENT:

DOCTOR: \_\_\_\_\_ DATE/TIME: \_\_\_\_\_

LOCATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

### WHEN TO START YOUR DROPS:

- Start your eye drops as soon as you fill the prescription and arrive home.
- Start your eye drops after your follow-up appointment.

If you have any questions regarding your prescription, ask your surgeon during your follow-up appointment, or call the surgeon's office.

### WHAT TO EXPECT AFTERSURGERY:

- Your eye may feel slightly uncomfortable, itchy, irritated, light sensitive, teary and/or red. These symptoms should improve gradually.
- Your eye may take up to 6 to 8 weeks to heal.
- Your surgeon will advise you about when you can resume your regular activities.

### ⊘ WHAT TO AVOID:

- **Do not** touch your eye.
- **Do not** allow the tip of the eye drop bottle to touch your lashes or eye.
- **Do not** drive for 24 hours after surgery unless advised by a physician.
- **Do not** get soap or water directly in your eye for 2 weeks, and avoid swimming pools or hot tubs for 1 month (unless advised otherwise by your eye physician).
- **Do not** lift heavy objects weighing over 10 pounds.
- **Do not** drink alcohol for 24 hours after surgery



## HOW TO CARE FOR YOUR EYE:

- Wash your hands before and after applying drops.
- Start eye drops per your doctor's instructions and bring them to your follow-up appointment.
- Resume all previous medications and diet.
- Wear the plastic shield at bedtime to protect your eye for 1 week (or as instructed by your doctor).
- Keep your eye closed in the shower.
- Wear sunglasses during the day while outside.

## EMERGENCY CARE

If after surgery, you experience any of the following, please seek immediate medical attention:

- Increasing pain in the operative eye
- Decreased/dimming vision
- Increasing swelling
- Vomiting
- A fever (temperature of 38C or 101F)
- A gush of fluid or pus/discharge from your eye

Please go to the nearest emergency room. During regular business hours, contact your surgeon's office.

[www.kensingtonhealth.org/eye-surgery/about-us/surgeons](http://www.kensingtonhealth.org/eye-surgery/about-us/surgeons)

## ADDITIONAL INSTRUCTIONS:

If you are un-expectedly admitted to a hospital within 10 days of the procedure, please notify Kensington Eye Institute immediately (416-928-2132). Regardless of whether the cause of the admission pertains to the procedure or not.

## WE VALUE YOUR FEEDBACK!

**We would love to hear about your recent experience.**

Scan this QR code or go to [bit.ly/KHExperience](http://bit.ly/KHExperience) to complete the survey online.





## Preparing for your appointment at the Kensington Eye Institute

Dear patient,

In order to prevent the spread of respiratory illnesses, we have changed some policies that will impact you. Rest assured, we are committed to providing you with a safe environment during your visit and have taken every precaution to keep you safe.

### Things you should know before you visit:

- Please self-screen for COVID-19 and other respiratory illnesses on the morning of your appointment. If you are experiencing a new or worsening cough or cold, have a sore throat, fever, or runny nose, please alert us to your symptoms **by telephone before you arrive for your appointment.**
- Please arrive 60 minutes prior to your surgery time. **NOTE: If you arrive more than 60 minutes prior to your appointments, you will be asked to return to your car until 60 minutes before your appointment.** Often your surgeon's office will calculate this time for you and provide you with an arrival time. Please double-check with your surgeon's office if the time you were given is the arrival time or surgery time.
- **Due to limited space, the person bringing you to your appointment will not be able to accompany you to your appointment on the 6<sup>th</sup> floor.** Exceptions will be made for those who require mobility help or translation. Once translation/mobility help is complete, escorts will be asked to wait elsewhere. We will contact them when you are ready to be discharged and ask them to come to the pick-up area.
- For cataract surgery total visit time will be 1.5 to 2 hours from arrival.
- For glaucoma, retina or cornea surgery, total visit time will be 2 to 3 hours from arrival.
- **You must put on a mask before entering the facility and must wear one for the entire duration of your visit.** If you are accompanied by an aide or translator, they must also wear a mask as well. A mask dispenser will be available near the entrance of the clinic.
- Do not wear disposable gloves as they provide a false sense of security and need to be sanitized with hand sanitizer. The hand sanitizer erodes the plastic, rendering plastic gloves useless.
- **Avoid using cash.** Credit and debit payments are preferred to minimize contact.
- Please be respectful to our team as they are here to ensure your health and safety.

If you have any questions or concerns about the instructions above, please call us at 416-928-2132. Thank you.