Patient Identification

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 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 __________________________________

____________________________ ____
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.

Patient Identification

Booking Sheet

CASE	Date of Case	Time of Case	Patient's Name (First-Middle-Last)		Male □ Female □
	Procedure(s)		Eye □ Left or □ Right	**Premium** IOL Type	Diopter
	Surgeon		Type of Anesthesia	Surgical Time (that case will take)	
	Physician's office contact (who scheduled the case with KEI)			Date case was scheduled with KEI	
	Special equipment/instrumentation/supplies requested or required			Previous KEI patient □ Yes □ No	
	Anesthesia consult required	□ Yes □ No	Date of Consult	Time of Consult	
	Ultrasound required	□ Yes □ No	Date of U/S	Time of U/S	

PATIENT	Home Address		
	Home Telephone Number	Date of Birth (**month/day/year**)	OHIP Number
	Alternate Contact Name	Alternate Contact Relationship	Alternate Contact Telephone

Wait Time information is **mandated** by MOH please complete **before faxing**.

WAIT	Date of Decision to Treat	First Eye for Cataract Surgery?	Yes No	Visual Acuity □ 1 – better than 20/40 □ 2 – 20/40 up to 20/200 □ 3 – 20/200 or worse
	Patient Classification Level	□ 0 (Other) □ Class 1 □ Class 2	□ Class 3 □ Class 4 □ Class 5	

Note: please enter all Dates as month/day/year

Patient Identification

Patient Name

Date of Birth

Date of Surgery

Surgeon

Pre-operative Patient Questionnaire

NOTE: To be completed by patient and returned to surgeon's office

Check the correct box for each question.

No	Yes	
☐	☐	Have you ever had a heart attack?
☐	☐	Do you ever have chest pain or angina?
☐	☐	Do you have high blood pressure?
☐	☐	Do you have pacemaker / rhythm problems?
☐	☐	Do you have sleep apnea?
☐	☐	Do you have a cough, asthma, bronchitis or emphysema?
☐	☐	Do you get short of breath climbing one flight of stairs?
☐	☐	Do you smoke? How many cigarettes per day? ______
☐	☐	Do you drink alcohol?
☐	☐	Any history of liver disease, jaundice or hepatitis?
☐	☐	Any indigestion, heartburn or hiatus hernia?
☐	☐	Do you have any kidney trouble?
☐	☐	Do you have diabetes?
☐	☐	Any history of thyroid problems?
☐	☐	Any numbness or weakness of arms or legs?
☐	☐	Any history of epilepsy, stroke, TIA?
☐	☐	Have you or members of your family had problems with anesthetics?
☐	☐	Do you have any capped, loose or false teeth?
☐	☐	Any chance you could be pregnant?
☐	☐	Do you bruise or bleed easily?

List your allergies: ____

List your medications: ____

List any operations you have had: ____________________________________

Additional information for the anesthetist/health care provider (for example, if you are seeing a heart doctor, lung doctor or other specialist, please list and inform your surgeon or nurse): ____

____

Completed by: __________________________ If not the patient, state relationship: _________

print your name

______________________________ Date: _______________

your signature

Patient Identification

Pre-operative History and Physical Examination

Note: to be completed by patient's primary care physician.

Patient Name: ________________________

Date of Surgery: __________________ Surgeon(s): ______________________________
month/day/year

Proposed surgery: ____

Allergies: _______________________ Medications: ______________________________
name and dosage

Past medical and surgical history: ____

Functional Inquiry:

	Normal	**If Abnormal, describe**
Neurological	□	
Cardiovascular	□	for significant heart disease, please attach recent EKG
Respiratory	□	
Gastrointestinal	□	
Genitourinary	□	
Endocrine	□	
Hematological	□	
Musculoskeltal	□	

Physical Examination:

Heart Rate:	Respiratory Rate:	Blood Pressure:	Height (cm):	Weight (kg):

System	**Normal**	**Abnormal**	**System**	**Normal**	**Abnormal**
General	□	□	Head, Eyes, Ears, Nose, and Throat	□	□
Neck	□	□	Abdomen	□	□
Lungs	□	□	Musculoskeletal	□	□
Heart	□	□	Neurological	□	□
			Skin and Hair	□	□

Describe Abnormalities: ____

____

Impression: ____

____

Date: __________ Time: __________ PRINT Name: __________________________MD
Month/Day/Year HH:MM

MD Phone: ___________ MD Fax: ____________ Signature: ___________________________MD

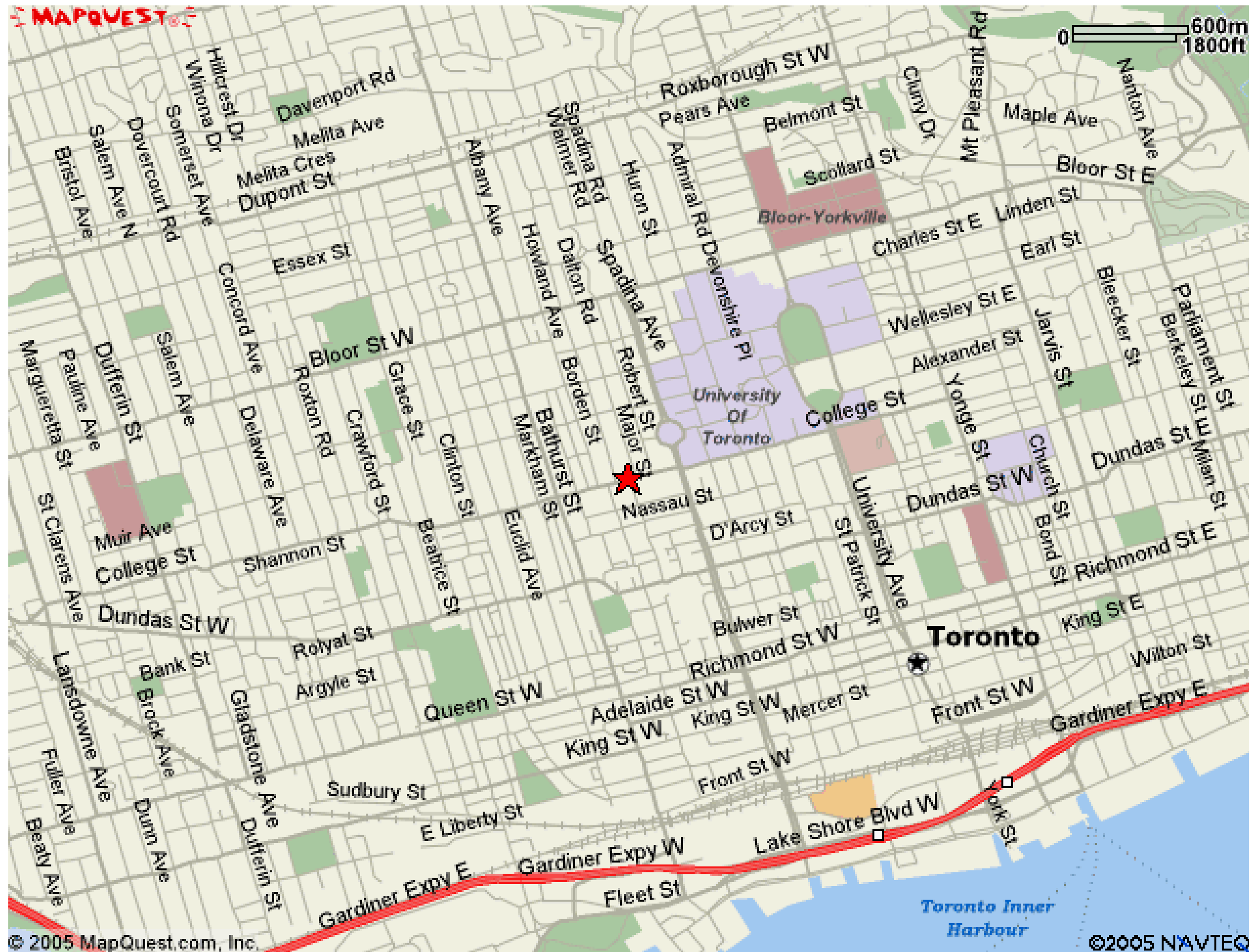
Patient Identification

Preop drop protocol:

Vigamox ☐
Cyclogyl 1%
Mydfrin 2.5%
Tetracaine

Voltaren ☐

____ MD
Signature



Kensington Eye Institute is located at:
340 College Street.
6th Floor
Toronto Ontario
416-928-2132

Underground Parking Garage is located behind 340 College Street (via Brunswick Avenue)
The garage is open from 6:45am to 10:00pm from Monday to Friday and Saturday to Sunday from 8:00am to 6:00pm