NORTH TORONTO EYE CARE
LASER & EYE SPECIALISTS

You are Scheduled for Cataract Surgery at TLC Yonge and Eglinton 2345 Yonge St. Suite 212

Your _____eye is scheduled for:_____

Your _____eye is scheduled for:_____

Time will be issued 1 week prior to surgery.

Cataract surgery is a fast and easy procedure. The total time spent at the centre is about 3-4 hours. During the procedure you will receive an IV to give you medication to stay relaxed, because of this medication you may feel sluggish for a few hours post surgery and you MUST have someone accompany you home.

Before you have surgery

- Please have your pre-op forms faxed to 416-748-8582. You must also see your family doctor to have the doctor fill out forms. If this is your second surgery you do not need to have them filled out again.
- Fill your prescription at the pharmacy and then start your drops 2 days before surgery. If this is you second eye please get a second set of drops, you have a repeat on the original prescription.

Drop Instructions

	Drops:	Besivance	Lotemax Gel	Nevenac
Before Surgery	2 days before surgery	1 drop/ 3 times a day	1 drop/ 3 times a day	1 drop/ 3 time a day
After Surgery	Until bottle is empty	Continue 1 drop/ 3 times a day until the drops run out	Continue 1 drop/ 3 times a day until the drops run out	Continue 1 drop/ 3 time a day until the drops run out

On the Day of Surgery

- Do not **eat any food** after midnight the night before surgery
- Do not **drink any fluids** other then water, apple juice, herbal tea, vitamin water, or Gatorade (drinks you can see through) up to 3 hours before surgery. Caffeinated beverages like tea and coffee, carbonated beverages like ginger-ale and sprite, and all alcoholic drinks, are **strictly forbidden before surgery**. You must stop all liquids 4 hours before surgery.
- Take your **Blood Pressure** and all other prescribed pills on the morning of your surgery
- **Do not** take your **Diabetes pills** on the morning of surgery
- Remember to take your prescription eye drops before you leave for surgery
- Do not bring any valuables to the facility or wear any makeup
- Please bring a valid form of payment (visa, debit, mastercard, or cash)
- If necessary, please arrange for a family member /friend to act as a translator
- Please arrange for an escort to accompany you home
- You will not be able to drive a car for 24 hours post surgery

After your Surgery

POST OP Visit #1: Will be done the same day as your surgery
POST OP Visit #2: Your post op will be arranged approximately 5 days- 1 week post surgery, you will receive the date on the day of surgery.
POST OP Visit #3: Please schedule an appointment with your optometrist at least one month after your second eye.

- Your eyes will burn and itch after surgery. Use lubricating eye drops that are found in the black kit as often as needed.
- You will receive a plastic shield on the day of surgery. Please wear the plastic shield while you are sleeping or lying down for 3 days/nights.
- Do not put any pressure or rub your eye. You may wipe the corners of your eye gently with a clean tissue of face cloth.
- You may resume light activities, but avoid heavy lifting, straining, or exercising for the first week after surgery. Ask your surgeon when you may resume work and driving.
- You may shower or bathe as normal but keep direct water out of your eyes for the first 3 days. You may wash your hair after 3 days.
- You should see your optometrist in 1 month to get new glasses. You can also remove the lens for the operated eye from your glasses in the mean time.

Should you have a sudden or worrisome loss of vision in the first week or two after surgery, it can be the start of a very serious eye infection and you should go to the emergency room immediately.

TLC _____

FACILITY VERIFICATION OF INFORMED CONSENT
FOR VISION CORRECTION SURGICAL PROCEDURE
ONTARIO, CANADA

I have reviewed with my surgeon the information necessary to reach an informed choice of whether or not to undergo vision correction surgery. My physician has already discussed my candidacy for vision correction surgery and the risks, side effects, complications, benefits, and alternatives of the surgery in great detail. I have had the opportunity to ask questions of my surgeon and all questions have been answered to my satisfaction.

By signing this form I am consenting to have the vision correction procedure performed at _____ (the "Facility") on my **RIGHT / LEFT** (circle one) eye. In the event I require additional surgery at a later date there may be additional fees due to the Facility at that time.

I understand that the Facility is owned or operated by TLC Vision (USA) Corporation, or its subsidiaries or its subsidiaries (jointly referred to herein as "TLC"). I understand my surgeon is <u>not</u> an employee or an agent of TLC and that TLC has no control over my surgeon's practice of medicine. I agree that TLC has not made any representations or warranties regarding my surgeon, my candidacy for the surgery, the surgery itself or the surgical result. I understand that my candidacy for vision correction surgery is decided solely by my surgeon. I understand that I am not a TLC patient and TLC is not my health care provider.

I certify that I have read or have had read to me the contents of this form. My surgeon has explained and I understand the risks, side effects, complications, benefits, and alternatives for this vision correction surgical procedure. I have already consented to have my surgeon perform this vision correction surgical procedure, and I do hereby consent for this Facility to provide my surgeon with the facility, equipment and support requested by my surgeon to perform and complete my vision correction surgical procedure.

Patient's Signature _____

Patient's Name (print)_____

Date_____

TLC Parties Representative Signature _____

TLC Parties Representative Name (print)_____

TLC _____

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Patient's Signature _____

Patient's Name (print)_____

Date_____

TLC Parties Representative Signature _____

TLC Parties Representative Name (print)_____

PATIENT REQUEST FOR NON INSURED SERVICES

I _____ have been diagnosed as having a cataract(s) and am therefore seeking treatment from Dr. _____ for the purpose of having this cataract(s) removed. I am also seeking other custom vision correction (CVC) services for cosmetic reasons, specifically, for the purposes of trying to eliminate or reduce the need to wear glasses or contact lenses.

I have been informed and I confirm that I am aware of the following:

1. I understand that the medically necessary components of cataract surgery are covered by OHIP, and that I have been offered an entirely funded procedure.

2. It is possible, at the same time or back to back, that my operating surgeon can perform custom vision correction (CVC) services for me that are in addition to the removal of my cataract(s) and my cataract surgery. These CVC services are intended to enhance my quality of vision and reduce my future need for prescription eyewear and are completely optional.

3. The Ministry of Health and Long-term Care does not consider these CVC services to be medically necessary and accordingly, they are not funded by OHIP. As a result, I will be personally responsible to pay for the CVC services that I elect to receive; I understand that I am being given a credit for the medically necessary lens provided by OHIP;

4. The various treatment options available to me have been discussed with me in detail and it is my decision and desire, in addition to my cataract procedure, to receive CVC services;

5. I have voluntarily chosen to receive the non-insured services outlined in the invoice attached as Appendix A and I undertake to be responsible for the associated fees.

Date:_____

Patient Name:_____ Signature:_____

Witness Name:_____ Witness Signature:_____

SURGISERVICES

Informed Consent for Conscious Sedation

Name: _____ Date of Birth: _____

Age: _____ Date: _____

I understand that the following has been provided for me so that I may be informed of the choices and risks involved with having a procedure performed under conscious sedation also sometimes referred to as intravenous(iv) sedation or sedation alone. It is my understanding that this information has been presented to enable me to make well-informed decisions concerning my treatment, not to make me anxious. My choices for this procedure are local anesthetic without sedation or local anesthetic with intravenous sedation.

I have been informed that aside from drowsiness, the most frequent side-effects of intravenous sedation include, but are not limited to, nausea, vomiting, and inflammation with tenderness and/or bruising around the intravenous site. Depending on the procedure performed, some degree of post-operative pain is to be expected. Since sedation may cause drowsiness and incoordination that may be enhanced by the use of alcohol or drugs, it is understood that (other than the usual prescription medications or medication prescriptions provided for the relief of post-operative discomfort by the surgeon, dentist, or anesthetist) they are to be avoided until completely recovered from the effects of sedation. I understand that the operation of any vehicle or any hazardous device/machine, or the making of any important decisions is to be avoided for at least 24 hours or until completely recovered from the effects of sedation. I understand that I should be accompanied to my residence by a responsible adult and that I should be in the care of a responsible adult for 24 hours following sedation to ensure I am attended to should the need arise.

I understand that on rare occasions there are sedation-related complications which include, but are not limited to, pain, hematoma, numbness, infection, swelling, bleeding, skin discolouration, allergic reaction, and fluctuations in heart rhythm and/or blood pressure. I further understand and accept the extremely remote possibility that complications may arise which may require hospitalization, result in brain damage or death. I have been made aware that local anesthesia carries with it the least amount of risk and sedation a greater amount of risk. However, local anesthesia alone may not be appropriate for some patients or procedures.

I understand that sedative medicines may be harmful to an unborn child and could result in spontaneous abortion or cause birth defects. Recognizing these risks, I accept full responsibility for informing the anesthetist of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of sedation. For similar reasons, I understand that I must inform the anesthetist if I am a nursing mother.

I hereby authorize and request the anesthetist or his/her staff to contact persons on my behalf and obtain any previous or current medical records/information when needed to properly assess my health status prior to sedation.

I hereby authorize and request the anesthetist to perform sedation as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned sedation. I consent, authorize, and request the administration of such sedative(s) by any route that is deemed suitable by the anesthetist. It is the understanding of the undersigned that the anesthetist will have full charge of the administration and maintenance of the sedation, and that this is an independent function from the surgery or dental work.

I have been fully advised and completely understand the alternatives of conscious sedation and accept all the possible risks and consequences. I acknowledge receipt of and completely understand both pre-operative and post-operative sedation instructions. It has been explained to me and I accept that there is no warranty or guarantee as to any result and/or cure. I have had the opportunity to ask questions about my sedation and I am satisfied with the information provided to me.

I hereby acknowledge that I am a resident in the province of Ontario and I agree that the resolution of any and all disputes arising from or in connection with the care provided by the anesthetist as well as his or her agents and/or delegates shall be governed by and construed in accordance with the laws of the Province of Ontario and that the Courts of the Province of Ontario shall have the exclusive jurisdiction.

I have had adequate time to discuss the sedation with Dr. _____ and my questions have been answered to my satisfaction.

The responsible adult who will be with me at my residence is: _____

Patient's Name: _____ Signature: _____

Witness Name: _____ Signature: _____

Date: _____

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The responsible adult who will be with me at my residence is: _____

Patient's Name: _____ Signature: _____

Witness Name: _____ Signature: _____

Date: _____

Please have family doctor complete this form 2 weeks prior to surgery. Please fax form to 416-748-8582.

SURGISERVICES

History and Physical

To be completed by your family physician.

Patient's Name: _____ Age: _____ Height: _____ Weight: _____

Past Medical and Surgical History:

Medications:

Allergies:

Labs Investigations (ie EKG, CBC, etc., if done):
Please include copies if done.

Social History:

Physical Exam:

Vitals: HR: BP: sat(if done):

Head & Neck:

Chest:

CVS:

Abdomen:

MSK/CNS:

Date: _____ Signed: _____MD/RN

Please complete questionnaire
and fax to 416-748-8582

SURGISERVICES

Preanesthetic Questionnaire

		Yes	No	Do not Know
1.	Do you have any heart trouble?	☐	☐	☐
2.	Have you ever had a heart attack?	☐	☐	☐
3.	Do you ever have chest pain or angina?	☐	☐	☐
4.	Do you have a pacemaker or ICD (implantable cardiac defibrillator)?	☐	☐	☐
5.	Do you have high blood pressure?	☐	☐	☐
6.	Do you ever have difficulty with your breathing?	☐	☐	☐
7.	Do you get short of breath climbing one flight of stairs?	☐	☐	☐
8.	Do you have a cough?	☐	☐	☐
9.	Do you have asthma, bronchitis or emphysema?	☐	☐	☐
10.	Do you have sleep apnea?	☐	☐	☐
11.	Do you smoke?	☐	☐	☐
	If yes: Cigarettes per day?_____ # Years smoking?_____			
	If no: Are you a lifetime non-smoker?	☐	☐	☐
	If you stopped smoking: When?_____ Cigarettes per day?_____ #Years smoking?_____			
12.	Any history of jaundice or hepatitis or liver disease?	☐	☐	☐
13.	Do you have a bleeding disorder?	☐	☐	☐
14.	Do you have diabetes?	☐	☐	☐
15.	Any history of thyroid problems?	☐	☐	☐
16.	Do you have any kidney problems?	☐	☐	☐
17.	Do you have Epilepsy or have you ever had a seizure or convulsion?	☐	☐	☐
18.	Have you had a stroke?	☐	☐	☐
19.	Have you ever had a blood transfusion?	☐	☐	☐
20.	Have you had cortisone, prednisone or steroids in the last 6 months?	☐	☐	☐
21.	Have you or members of your family had problems with anaesthetics?	☐	☐	☐
22.	Do you have a history of difficult airway or difficult intubation?	☐	☐	☐
23.	Do you suffer from heart burn or acid reflux?	☐	☐	☐
24.	Do you have any capped, loose or false teeth?	☐	☐	☐
25.	Do you have a family history of Malignant Hyperthermia?	☐	☐	☐
26.	Do you have muscle weakness or problems with your joints?	☐	☐	☐
27.	If female, and of childbearing age, is there a possibility that you are pregnant?	☐	☐	☐
28.	Do you have HIV?	☐	☐	☐
29.	Do you have a drug addiction or use any recreational medications?	☐	☐	☐
30.	Have you had a recent weight loss? _____or gain? _____ How much?_____	☐	☐	☐
31.	Are you taking any tranquilizers or anti-anxiety medication?	☐	☐	☐
32.	Have you ever had a blood clot in your limbs or lung?	☐	☐	☐

33 List how much alcohol you drink:_____

34 List your allergies:_____

35 List any operations and/or major illnesses you have had:_____

36 List your medications (including over the counter and herbal medications and puffers or inhalers):

Current Medications	Dosage

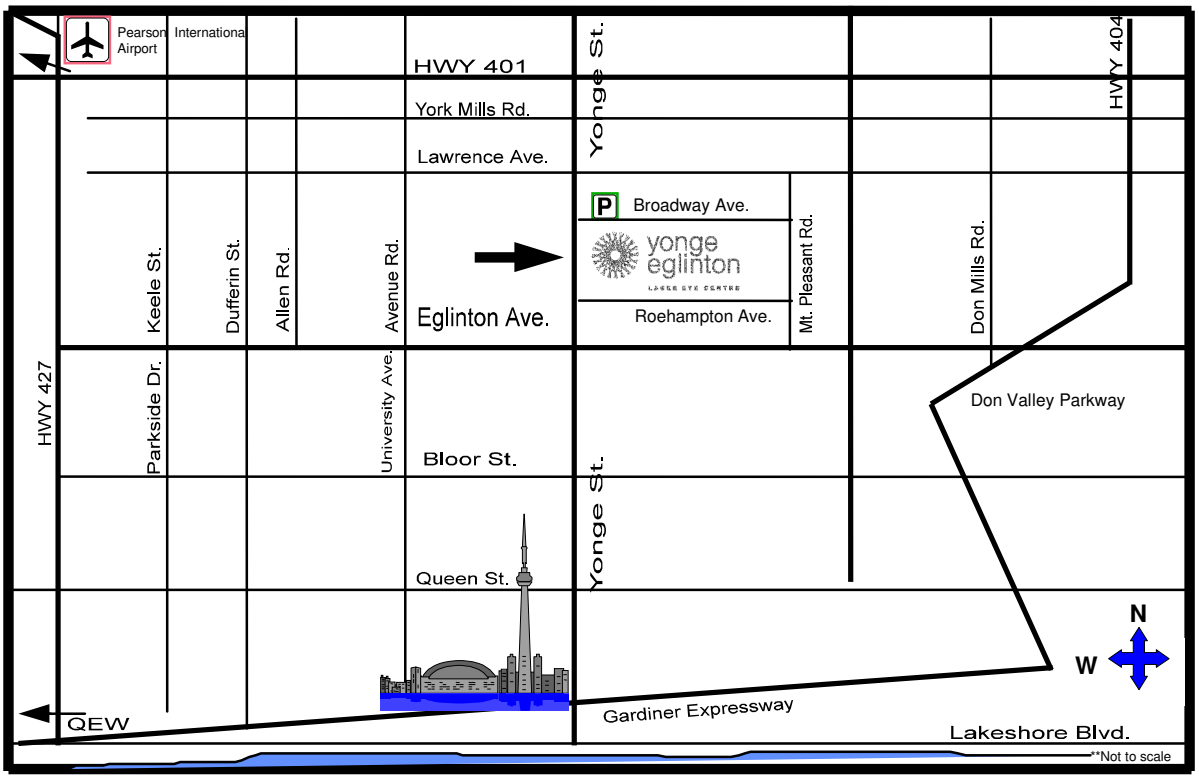
Completed by:_____
If not patient, state relationship:_____

Signature:_____
Date:_____

TLC Laser Eye Centers | yonge eglinton

2345 Yonge St., Suite 212
Toronto, Ontario M4P 2E5
Phone: 416-733-2020 - Fax: 416-733-0316

PARKING INFORMATION & DIRECTIONS



Parking:
Entry to the parking lot is on Broadway Avenue. The parking ramp is on the south side of the street (East of the apartment building at 7 Broadway Avenue). Take the Office elevators up to "L" or Lobby. Please exit the elevators and turn right to Suite 212.

There are automated machines at every level.
You can purchase a pass from these machines at a discount by entering coupon code "212".

How To Use The Machine: ***Machine only takes coins***

1. Enter licence plate number
2. Select number 5 for "More Options" until you see either
    1. TLC-6PM (Day Pass, valid from 6am to 7pm) or
    2. TLC-6AM (Evening/Weekend Pass, valid from 5pm to 6am)

    and press the corresponding number.
3. Enter special discount parking code 212.
4. Machine will request the discounted payment.

Directions from HWY 401:
- Take Hwy 401 to Yonge Street south exit.
- Follow Yonge Street south and turn left (east) on Broadway Avenue. **Tim Hortons is at the corner**

Directions from Yonge Street:
- We are located 2 blocks North of the Yonge/Eglinton subway station on the East side of Yonge between Roehampton Avenue and Broadway Avenue (besides Shoppers Drug Mart).