INTRAVITREAL INJECTION
PROCEDURE NOTE

PATIENT: ___________________________________

DOB: _____________________________________

DATE OF SERVICE: _____________________________

INTRAVITREAL ________________________: _______________ EYE.

INDICATION FOR SURGERY:_____________________________________

PROCEDURE: The patient was brought into the surgical suite and placed in the supine position. A drop of Alcaine was placed in the surgical eye and retrobulbar block / topical 4% Lidocaine was performed to achieve anesthesia in the surgical eye. The surgical eye was then prepped and draped in the usual sterile fashion. A speculum was placed sterilely in the surgical eye. Four drops of Zymar have been placed every five minutes times four prior to the surgical procedure to the surgical eye while the patient was dilating. O.1 cc of ________________________(drug) was drawn up in a sterile fashion in a 3cc syringe drawing up the _____________________(drug) in the syringe for intravitreal injection. Using a 30 gauge needle, 0.1 cc (corresponding to ________________________) was injected into the mid-vitreous cavity as slowly as possible under direct visualization with a 28 diopter lens and indirect ophthalmoscopy through the pars plana at 3.75 mm posterior to the limbus without complication. The patient tolerated the procedure well. After the injection, the intraocular pressure was measured and found to be _______ with the central retinal artery **closed/patent/winking**. A paracentesis **was/was** not performed and a drop of _____________ was placed over the surgical eye. Zymar was placed every five minutes times four over the surgical eye as the patient waited in the waiting area. A post-operative IOP was measured and found to be _______ approximately 20 minutes after the injection and indirect ophthalmoscopy confirmed no retinal tears or detachment or vitreous hemorrhage and the patient's vision reported as normal as it was prior the procedure. There were no complications. The patient was instructed to return one day following surgery at (time)___________ on (date)________________ and to call immediately upon any sudden pain, decreased vision, flashing lights, floaters or other symptoms of retinal tears or detachment. The patient will be using Zymar four times a day following the procedure.

____

Eric S. Mann, M.D., Ph. D.

ESM/mat

RECEIPT OF POST-OP INSTRUCTIONS

I ______________________________ have been given postoperative instruction information. I have had the opportunity to read, understand and ask questions regarding my planned surgical procedure(s). Dr. Mann has explained this procedure to me in depth. I have been informed in regard to the potential benefits, complications, risk and alternatives of the procedure. Sufficient time was allowed for me to ask questions and these questions were answered to my satisfaction.

____________________________ ______________

Patient signature Date

____________________________ ______________

Witness signature Date

The Retina Group LTD. P.C.

Eric S. Mann, M.D., Ph.D.

Diseases & Surgery of the
Retina Macula & Vitreous

POSTOPERATIVE INSTRUCTIONS FOLLOWING EYE SURGERY

ACTIVITY:

Avoid driving, bending, heavy lifting, vigorous coughing and/or sneezing, straining with bowel movements, vomiting, and any other activity that increases intra-ocular pressure. No exercise or physical exertion for 4-6 weeks.

WOUND CARE:

1. Avoid squeezing eyelids shut or touching eye.
2. During the day, keep operated eye covered with eyeglasses or shield.
3. At night, always wear shield to prevent rubbing eye and causing injury.
4. Wear dark glasses if photosensitivity occurs.
5. Crusting on the eyelids may be removed with a **clean** washcloth run under warm tap water.
6. DO NOT PRESS ON THE EYE.
7. Call your surgeon if you develop any signs and symptoms of infection: eye pain, decreased vision, itchy/watery eyes or increased redness/swelling/discharge.
8. Wash your hands before giving eye drops.

SAFETY PRECAUTIONS:

1. To avoid falls and/or accidents, remove throw rugs, clutter, cords and furniture in walking paths.
2. Turn head fully to affected side to view objects.
3. Use up and down head movements to judge stairs and oncoming objects. MOVE SLOWLY.

POSITIONING:

______NONE ______SIDE DOWN ______FACE DOWN ______SIT UP ______DAYS

1. Do not lay prone or flat on back if special positioning is necessary.
2. Maintain special positioning as much as possible, taking a 5 minute break every 120 minutes.
3. Do not ascend altitudes greater than 2000 feet; do not fly in an airplane; no non-ocular surgery unless both the surgeon and anesthesiologist know you have gas in your eye.

MEDICATIONS:

1. Avoid over-the-counter medications unless discussed with your doctor.
2. Shake eye drops before applying; shake Pred Forte 1% Eye Drops 30 times before using.
3. Avoid contaminating tip of eye drop applicator by touching eye with tip.
4. Wait three-five minutes between application of different eye drops.
5. Take Tylenol for pain.
6. Avoid aspirin, aspirin containing products such as Anacin and anticoagulants such as Heparin and Coumadin unless approved by your doctor.

FOLLOW UP CARE:

Follow up care is a critical part of a successful surgery. Your surgeon needs to assess your eye healing and see that you are recovering safely.

YOUR SCHEDULED FOLLOW UP APPOINTMENT IS :________________________.

REPORTABLE SIGNS:

Call Dr. Mann immediately if any sudden eye pain not relieved by Tylenol, increased redness/swelling/discharge, or loss of vision or any systemic complaint.

EMERGENCY PHONE NUMBER TOLL FREE: 866-856-7882
OFFICE NUMBER MISSOURI : 314-835-9400
OFFICE NUMBER ILLINOIS: 618-632-8100

CONSENT SPECIAL/INFORMED TO SURGERY OR OTHER PROCEDURE

Name: ____ Date: _______________

Medical record number _______________________________

1. I hereby authorize Dr. Mann and / or such assistants, associates, or other health care providers that may be selected by him, to perform the following procedure (s)
INTRAVITREAL INJECTION ______________________________EYE

2. Dr. Mann has discussed with me the procedure(s) listed above and the items of information that are briefly summarized below:
 a. The nature and purpose of the proposed procedure(s): ___________________
 ____
 b. The risks and possible consequences of the proposed procedure(s), including the risk that treatment may not accomplish the desired objective(s) and including, but not limited to: decreased vision, pain , infection, increased intraocular pressure, bleeding, cataract, retinal detachment or retinal break, loss of vision ,loss of globe, need for further surgery
 c. All reasonable alternative treatment, including risks, probable effectiveness of each and consequences if this proposed treatment is not received:
 ____

3. I am aware that, in addition to the risk specifically described in Item 2 above, there are other risks, such as severe loss of blood, infection, cardiopulmonary arrest, respiratory difficulties, injury to proximate/adjacent blood vessels, nerves, organs or structures, unanticipated allergic reaction to substances, pressure/position related injuries and other risks related to the performance of any surgical procedure.

4. I acknowledge that no guarantees have been made to me as to the results of the procedure(s) and am also aware that complications and risks may occur despite precautions.

5. I consent to the performance of unforeseen operation(s) and procedure(s) in addition to or different from those now contemplated and describe herein that the named doctor and his associates or assistants may deem necessary or advisable during the course of the presently authorized procedure(s).

6. I consent to the administration of such anesthetics as may be considered appropriate by the physician responsible for anesthesia administration or such assistants or associates as may be selected by him. I understand that this procedure is to be performed using **topical and/or retrobulbar** anesthesia. I understand that all types of anesthesia involve some risk. I further understand that if a regional, spinal or epidural anesthesia is planned, it may be necessary to also administer a general anesthetic during this procedure, and I consent to the administration of a general anesthetic. I understand the risk of a general, spinal, epidural or regional anesthesia include, but are not limited to, mouth and/or throat pain or injury, cardiopulmonary arrest, cardiac arrhythmias, heart attack, respiratory difficulties, stroke, brain damage, headache, backache and other sensory, nerve, focal and systemic injuries.

7. I also consent to the administration of blood or blood components, drugs, medicines and other substances considered advisable by the physician(s) responsible for this procedure and the use of x-rays or other diagnostic testing, procedures and devices, which the above-named physician or his associates, consultants or assistants may consider useful.

8. I hereby authorize The Retina Group LTD PC or staff to preserve for scientific or teaching purposes or to otherwise dispose of any tissues, parts, organs, or implants removed during this procedure.

9. For teaching or educational purposes, I consent to the admittance of students, staff or other observers to the operating and procedure rooms, and to the taking of any videos or photographs deemed appropriate or necessary by the physician in the course of the procedure(s). I also consent to the taking of photographs or videos for the purpose of documenting the condition or procedure in the medical record. I understand that if data, photographs, videos or other information are used for teaching/educational purposes or for scientific publication, that my (the patient's) identity will remain confidential unless otherwise authorized by the undersigned.

10. I certify that I have read or have had the above information read to me and that I understand the above consent to operation or diagnostic procedure, that the explanations referred to were made to my satisfaction and I hereby give my informed and voluntary consent to the proposed procedure(s) or operation(s).

Signature of patient:

____

If the patient is unable to give informed consent because of physical or mental incapacity or is a minor (under 18 and unemancipated), complete the following:
Patient is unable to give consent because ____
____
____

:
____
Witness to signature

I certify that I have explained to the above individual the nature, purpose, risk and potential benefits of the above procedure and have answered any questions that have been raised.

____
Signature of Physician