NORTHWEST HILLS EYE CARE

PERMISSION FOR CLINICAL LOW VISION EXAMINATION AND USE OF EYE MEDICATIONS

PATIENT NAME: _____

When patients are seen for a clinical low vision evaluation, it may be necessary for Dr. Miller to use eye drops in order to check the intraocular eye pressures or to dilate the pupils of the eyes in order to examine the eyes more thoroughly and comprehensively. These procedures may be necessary in order to check the general health of the eyes and to rule out any new or active pathology.

Although adverse side effects are rare with the use of such eye drops, potential side effects can include:

1) allergic reactions to the drops, which can include stinging, burning, itching, rash, and breathing problems,
2) photophobia (extreme light sensitivity)
3) precipitation of an attack of angle closure glaucoma
4) temporarily blurred or cloudy vision, or
5) headache

The effects of these drops can last for a few minutes or up to four to six hours, during which time, vision may be blurred, especially near vision, which will make near tasks, such as reading, very difficult.

PLEASE BE SURE TO GIVE THE DOCTOR A COMPLETE LIST OF MEDICATIONS, including over the counter medicines, AND ALLERGIES!

My signature (adult patient or parent/guardian) on this permission form indicates that I will not hold Northwest Hills Eye Care, its employees, or Laura S. Miller, O.D. responsible for any adverse effects that might be part of the procedures for which I grant permission as follows:

CHECK ONE: LOW VISION EVALUATION

_____ I GRANT permission for me or my child to have a clinical low vision examination at Northwest Hills Eye Care by Dr. Miller and her staff.

_____ I DO NOT GRANT permission for me or my child to have a clinical low vision examination at Northwest Hills Eye Care by Dr. Miller and her staff.

NORTHWEST HILLS EYE CARE
USE OF EYE MEDICATIONS

PATIENT NAME: _____

CHECK ONE: **USE OF EYE MEDICATIONS DURING EXAMINATION**

_____ I GRANT permission for topical ophthalmic medication(s) i.e. eye drops to be used on me/my child as part of the clinical low vision examination if deemed necessary by Laura S. Miller, O.D. I acknowledge the potential adverse side effects, including the small risk of angle closure glaucoma, and the fact that I/my child may be light sensitive and have difficulty with near vision for a period of four to six hours after instillation.

_____ I DO NOT GRANT permission for topical ophthalmic medication to be used on me/my child as part of the clinical low vision examination, knowing that this will preclude the doctor from having the maximal opportunity to examine the health of me/my child's eyes and to detect retinal or other ocular diseases such as glaucoma, which might lead to further severe vision loss, blindness or death.

I understand and acknowledge by my signature below, that my refusal to give permission for use of eye drops does not preclude my/my child's opportunity to have a clinical low vision examination.

Signature: _____ **Date:** _____
(Patient or parent/guardian if patient is a minor.)

RETURN COMPLETED FORM TO NORTHWEST HILLS EYE CARE ALONG WITH OTHER REFERRAL INFORMATION ONE WEEK PRIOR TO LOW VISION EXAMINATION.