Marion Eye Centers

CONSENT FOR FLUORESCEIN AND/OR INDOCYANINE GREEN ANGIOGRAPHY

I, _____, agree to have a fluorescein/indocyanine green angiography examination performed by the Marion Eye Centers. I am aware of the usual affects from the dye, which is orange skin appearance for 6-12 hours after the procedure.

Less than 2% of the population receiving fluorescein/indocyanine green angiography experience reactions such as nausea, headache, upset stomach, vomiting, light-headedness, fainting, and hives.

I further understand that indocyanine green dye has a 5% iodine base and deny any known allergies to either iodine or shellfish. I further deny any abnormality of the liver and deny that I am pregnant.

I also understand certain reactions to fluorescein/indocyanine green dye rarely occurs, including but not limited to: heart attack, shock, convulsions, permanent disability, death, blindness, convulsions, swelling, and irritation of the veins, which are injected.

I realize fluorescein/indocyanine green angiography is a diagnostic procedure ordered by my ophthalmologists, Dr._____, in an effort to assist them to make appropriate decisions regarding diagnosis and treatment of my eye disorder.

A representative of the Marion Eye Centers has verbally informed me of what is involved for fluorescein/indocyanine green angiography and has explained the procedure, its purpose, side effects, and serious reactions, and I have no further questions that I would like to have answered. I understand the above statements.

I hereby authorize the Marion Eye Centers, its employees, and medical staff to perform a fluorescein/indocyanine green angiography procedure(s) on me on this date:_____.

SIGNED: _____ DATE: _____
(Patient or person authorized to sign)

WITNESS: _____ DATE: _____