

**Dr. Nicholas Skouras MD, FRCS, DABO**

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**Informed Consent for SLT Treatment**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Dr. Nicholas Skouras to perform a SLT laser trabeculoplasty on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ eye(s). I understand the purpose of this procedure is to apply laser spots to the drainage angle to attempt to decrease the pressure in the eye. Most of the time, this treatment leads to a reduction in intraocular pressure. The full effect may not be seen for several months. I understand that some individuals do not have any effect from the treatment and others may not experience enough decrease of pressure to reduce or stop medications.

I understand that I may still need to use glaucoma medications following the treatment. This treatment does not eliminate the possibility of future surgery for glaucoma. There is a small chance that inflammation within the eye may require additional medications as the eye heals. As with any procedure, there is a chance that the beneficial effect of the laser may not be adequate or “wear off” with time, and may need to be repeated.

I understand there is a small chance of increased pressure immediately following the treatment and I agree to follow up within 1 hour of the procedure unless otherwise instructed.

I understand the nature of the procedure, alternatives and the risks. All of my questions concerning the SLT treatment for glaucoma have been answered to my satisfaction.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_