AUTHORIZATION AND CONSENT:

I have been informed concerning the side effects of ________________________.

Alternatives to taking this medication have been reviewed. I have had the opportunity to ask questions. I am aware of the major side effects including:

____

____.

I request that the above drug be provided to me or the person named below for whom I am authorized to grant consent.

PATIENT NAME:____

ADDRESS:____

PATIENT SIGNATURE____

SIGNATURE OF PARENT
OR GUARDIAN:____

SIGNATURE OF PHYSCIAN____

☐ Note to referring M.D. Date: ___________ Fax Mail Phone

DISCLAIMER:

This is a sample consent form only and clinicians should obtain a hospital approved consent form at the individual institution specifically tailored to the condition being treated and the type of drug prescribed. Recommendations presented here should not be considered inclusive of all proper methods of care or exclusive of other methods of care reasonably directed to obtain the same results. The ultimate judgment regarding the propriety of any specific procedure or treatment must be made by the ophthalmologist in light of the individual circumstances presented by the patient.

This information is intended solely to provide risk management recommendations. It is not intended to constitute legal advice and should not be relied upon as a source for legal advice. If legal advice is desired or needed, an attorney should be consulted.