GENERAL CONSENT FOR MICROBLEPHARO EXFOLIATION (MBE) PROCEDURES

You have been given information about your condition and the recommended medical procedure to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. **Condition:** Dr. _______________has explained to me that the following conditions exist in my case: **Blepharitis**

2. **Proposed Procedure(s):** I understand that the procedure(s) proposed for treating my condition is MBE – Microblepharo Exfoliation

3. **Risks / Benefits of Proposed Procedure(s):** Just as there may be benefits to the procedure proposed, I also understand that medical and surgical procedures involve risks. These risks were explained to me by Dr. __________________.

4. **Complications; Unforeseen Conditions; Results:** I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

5. **Acknowledgements:** The available alternatives, some of which include **home lid scrubs**, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment have been explained to me by Dr. _________________. I understand what has been discussed with me as well as the contents of this form, and have been given the opportunity to ask questions and have received satisfactory answers.

6. **Consent to Procedure(s) and Treatment:** Having read this form and talked with the physicians and/or eye doctors, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my physician and/or eye doctor, and/or his/her associates assisted by hospital or office personnel and other trained persons as well as the presence of the observers. I further consent to the administration of such anesthetics and medication might be considered necessary or advisable by my physician.

____ ___________________________

Patient (Or person authorized to sign for patient) Date

____ ___________________________

Witness Date