

**JACQUELINE CO, M.D., PA**  
Richardson regional medical center  
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This form is designed to comply with the requirements of Texas Medical Disclosure

**DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES**

**TO THE PATIENT:** You have the right as a patient, to be informed about your condition and recommended surgical, medical or

Diagnostic procedure to be used so that you may take the decision whether or nor undergo the procedure after knowing the risk And hazards involved. This disclosure is not meant to scare you or alarm you. it is an effort to make you better informed so you May give or withhold your consent to procedure.

(we) voluntary request DR.CO

my physician, and associates. Technical assistant and other health care providers, as they may deem necessary to treat my condition, which has been explained to me as:

myogenic ptosis and excessive skin weighting down the eye lids.

(we) understand that the following surgical , medical and /or diagnostic procedures are planned foe me and (we) voluntary consent and authorize these procedure.

Myogenic ptosis repair with removal or excessive skin.

(we) understand that my physician may discover other or different conditions, which it required additional or different procedures plan those planned. I (we) authorize my physician and such associates, technical assistants and other health providers to perform such others procedures, which are advisable in their professional judgment.

(we) DO / DO NOT consent the use of blood and blood products as deemed necessary.

(we) understand that no warranty or guarantee has been made to me as to result or cure.

Just are they may be risk and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedure planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedure is the potential for infection, blood clot in eyes, lungs hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards occur in connection whit the particular procedure:

**INFECTION, BLEEDING, NEED FURTHER SURGERY. LOOS OF VISION. LOSS OF EYE.**

Possible complications, relative risks, symptoms, and treatments are as follow. These could include:

- Orbital hemorrhage with potential for permanent vision loss.
- Postoperative bruising that can be minimized by cold compresses and invariable dissipates.
- Infection that requires treatment with antibiotics and rarely. Hospitalization.
- Under correction with the potential for patients that may result in decreased frequency, amplitude and velocity of the blink and subsequent dry eye: severe overcorrection may results in eye lid closure problems and permanent effects on vision.
- Permanent double vision, an extremely rare complication that may necessitate prisms or even eye muscle surgery, and in extreme cases. Abnormal scarring, persistent lid swelling and other unusual skin changes can occur, specially in patients with thin, sensitive skin.

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(we) understand that anesthesia involves additional risks and hazards but (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures, I (we) realize the anesthesia may have be changed possibly without explanation to me (we).

(we) understand that certain complication may result fro the use of any anesthetic including respiratory problems, drug reaction. Paralysis, Brain damage or even death. Other risks and hazards, which may result from the use of general anesthetics, range from minor discomfort to injury to vocal cords. Teeth or eyes. I (we) understand that (we) have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and (we) have sufficient information to give this informed consent.

(we) certify this form has been fully explained to me. That (we) have read it or have it read to me. That the blanks spaces have been filled in and that (we) understand its consents.

**PATINET SIGNATURE:**

**Date:**

**WITNESS SIGNATURE:**

**Witness name:**

**Date:**

