ISLAND EYE SPECIALISTS

MICRONESIA'S REGIONAL EYE CENTER SINCE 1997

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EYE DILATION DISCLAIMER

Hafa Adai! Welcome and thank you for choosing Island Eye Specialists for all your eye healthcare needs.

Your eye examination may include, but may not be completely limited to the following tests:

- Slit lamp exam *(magnified view of the front of the eye)*
- Tonometry *(eye pressure check)*
- Funduscopy *(viewing of the retina / back of the eye)*

Island Eye Specialists may be dilating your eyes, which will remain dilated for about 3 to 12 hours depending on individual patient sensitivity. Patients may experience blurred vision making it difficult to read and/or drive. You may be at risk for tripping, falling, and being involved in a motor vehicle accident.

Please notify the office staff if you **do not** wish to have your eyes dilated. We will schedule an appointment for you to be dilated at your convenience.

Island Eye Specialists is a medical clinic and our priority is your eye health. If you wish to have your vision checked to determine the need for glasses or a change in prescription for glasses or contacts, please notify the staff immediately. Once your eyes have been dilated an eyeglass and/or contact lens prescription check cannot be done accurately and will require a separate visit.

IF YOU ARE DILATED TODAY, WE RECOMMEND YOU DO NOT DRIVE

You may be placed on medications such as eye drops or pills. In a very, very numerically small but finite (dilated existing) number of cases, these medications may cause fever, vomiting, tingling, or numbness in the hands or feet, kidney stones, bone marrow suppression (stopping the growth of blood cells being made in the body), skin rashes, Stevens Johnson Syndrome (extensive sloughing of the skin), blindness, infections of the eye, glaucoma (damage to the optic nerve due to pressure in the eye), cataract, or any number of allergic reactions including death.

If you develop any allergic reaction, please stop the medication and call our office. If you have any questions, please do not hesitate to ask.

THIS FORM COVERS THIS VISIT AND ANY SUBSEQUENT VISITS

_____ _____ _____
Print Name: Signature: Date:

---------- For Office Use Only ----------

Copy given to patient ( ) YES ( ) No IEC Staff: _____ Date: _____