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INFORMED CONSENT FOR DILATION OF EYES

WHAT IS DILATION?

Dilation is a procedure in which special eye drops are placed in your eyes to enlarge (dilate) the pupils. This allows your eye care provider to examine the inside of your eyes more thoroughly, including the retina, optic nerve, and blood vessels. A dilated eye examination is one of the most important tools for detecting eye diseases early, when they are most treatable.

WHY IS DILATION RECOMMENDED?

Access Health Vision recommends a dilated eye examination **at least once every two years** for most patients. For patients with diabetes, high blood pressure, a family history of eye disease, or other high-risk conditions, we recommend a dilated examination **at least once every year**. Dilation allows your doctor to check for:

- Diabetic retinopathy
- Glaucoma
- Age-related macular degeneration
- Retinal tears or detachments
- Cataracts
- Tumors or other abnormalities

WHAT TO EXPECT

The dilating drops typically take **15–30 minutes** to fully take effect. The effects of dilation usually last **4–6 hours**, but in some cases may last longer. During this time, you may experience:

- **Blurred vision,** particularly at near/reading distance
- **Sensitivity to light** — sunglasses are recommended after your exam
- **Difficulty driving** — you may wish to arrange for someone to drive you home
- Mild stinging when the drops are first applied

RISKS

Adverse reactions to dilating drops are **extremely rare**. However, in very rare cases, dilating drops can trigger a condition known as **acute angle-closure glaucoma**. This is a medical emergency and requires immediate treatment. Symptoms may include:

- Sudden, severe eye pain or headache
- Sudden blurred or decreased vision
- Nausea or vomiting
- Seeing halos or rainbow-colored rings around lights

If you experience any of these symptoms after dilation, contact our office immediately at (606) 546-4166 or go to your nearest emergency room.

Important: Because driving may be difficult after dilation, we recommend you make arrangements for someone to drive you home after your appointment. Access Health Vision is not responsible for any injuries or accidents that may occur from driving after dilation.

PATIENT CONSENT

I have read and understand the above information about dilation. I have had the opportunity to ask questions and have received satisfactory answers. I understand the benefits, risks, and possible side effects of dilation.

☐ **I CONSENT** to having my eyes dilated as recommended by my eye care provider.

☐ **I DECLINE** dilation at this time. I understand that declining may limit my doctor's ability to fully evaluate my eye health and I accept full responsibility for my decision.

PATIENT NAME (PRINTED) | DATE OF BIRTH

PATIENT / GUARDIAN SIGNATURE | DATE

WITNESS SIGNATURE | DATE