VISIORA
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حلول لرعاية البصر

INFORMED CONSENT FORM

For the Use of Contact Lenses in Corneal Refractive Therapy (Orthokeratology – Ortho-K)

This informed consent is prepared in accordance with:

- **The Saudi Law of Practicing Healthcare Professions** issued by Royal Decree No. (M/59) dated 04/11/1426H
- **The Ministry of Health (MOH) Informed Consent Guidelines**
- The Patient Rights regulations applicable in the Kingdom of Saudi Arabia

1. Patient Information

Full Name: .....
National ID / Iqama No.: .....
Date of Birth: .....
Medical Record No. (if applicable): .....

2. Description of the Medical Procedure

I hereby acknowledge that the healthcare practitioner has clearly explained to me the nature of the proposed procedure, which involves the use of **custom-designed therapeutic contact lenses for Corneal Refractive Therapy (Orthokeratology – Ortho-K)**.

This treatment aims to **temporarily reshape the cornea** in order to improve vision without surgical intervention.

I understand and acknowledge that:

- This procedure is **non-permanent**.
- Continued benefit depends on **strict adherence** to the prescribed wearing schedule and care instructions.
- Discontinuation of lens wear will result in the cornea returning to its original shape.

3. Alternative Treatment Options

I have been informed of alternative options available to me, which may include, but are not limited to:

- Spectacles (eyeglasses).
- Conventional contact lenses.
- Refractive surgical procedures (e.g., LASIK or other surgical options).

I confirm that I have been given adequate time to ask questions and consider these alternatives.

4. Clinical Examination and Suitability

I acknowledge that the necessary ophthalmic and clinical examinations have been performed and that, based on the professional assessment, my current ocular condition is **considered suitable** for this treatment at this time.
Current refractive status:

- Right Eye (OD):
- Left Eye (OS):

5. Risks and Possible Complications

I understand that while this treatment has potential benefits, the use of contact lenses carries possible risks, particularly if instructions are not followed. These may include, but are not limited to:

- Blepharitis or conjunctivitis.
- Corneal edema (swelling).
- Corneal inflammation or corneal ulcers.
- Corneal scarring, which may affect visual quality.
- Night glare, halos, or visual disturbances under low-light conditions.

6. Patient Responsibilities

I agree and undertake to:

- Strictly follow all instructions regarding lens wear, hygiene, cleaning, and follow-up visits.
- Immediately report and seek medical attention for any pain, redness, blurred vision, discharge, or abnormal symptoms
- **Accept responsibility for complications arising from misuse, non-compliance, or failure to attend follow-up appointments.**

7. Acknowledgment and Consent

I confirm that:

- The information provided to me has been explained in a clear and understandable manner.
- I have had the opportunity to ask questions and received satisfactory answers.
- I have not been coerced or pressured in any way.

Accordingly, I voluntarily and knowingly consent to undergo the above-described procedure.

Patient Name: .....
Signature: .....
Date: .....

Healthcare Practitioner Name: .....
Professional License No.: .....
Signature & Stamp: .....

This informed consent does **not** exempt the healthcare practitioner or the healthcare facility from legal liability in cases of proven medical negligence or professional misconduct, in accordance with the laws and regulations of the Kingdom of Saudi Arabia.