Dilation Consent Form

Dilation is an important part of a comprehensive eye exam. Dilation will make your pupil (the black part in the center of your eye) large so that Dr. Racette can get a better look at the back of the eye to check for any problems that can occur due to the following:

- Systemic diseases, such as Diabetes, High Blood Pressure, Cancer, and other conditions that can affect the eyes without obvious symptoms to the patient.
- Physical changes in your eyes, such as cataracts, glaucoma, retinal detachment, macular degeneration, and other conditions that can affect your vision.

The dilation will make readings things up close difficult, make lights seem brighter than usual, and can cause your vision to be blurry. This will last for approximately 3-5 hours, although it can last longer in some people. Most people will be able to drive once their eyes are dilated, as long as they have sunglasses. However, if you feel uncomfortable driving while your eyes are dilated, or you have never driven with your eyes dilated, it may be best to have a driver. Please note that there is no additional charge for having your eyes dilated.

It is strongly recommended to have your eyes dilated if:

- You are new to our office.
- You are diabetic.
- You are over the age of 45.
- You are nearsighted (myopia).
- You have been previously diagnosed with a condition in the back of the eye that needs yearly monitoring.

If you do not fit in the above categories, it is still recommended to have your eyes dilated every year and at the very least should be dilated every 2 years.

Please check one of the following:

____ YES, I would like my eyes dilated today if the doctor feels it is necessary, and I understand the side effects of dilation mentioned above.

___ NO, I do not want my eyes dilated today (see below).

In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information which may have been provided by having my eyes dilated.

Patient or Legal Guardian signature: _____ Date: _____

Patient or Legal Guardian name: _____