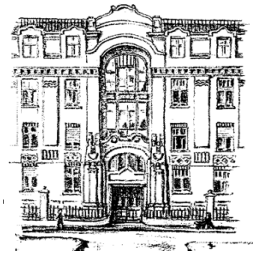
Title:
Treatment of Ocular Surface Inflammations With 1% Cyclosporine (Ikervis) Eye Drops

Protocol ID:
NNGYK/23414-1/2025

Informed Consent Form

Document Date:
June 10, 2025



SEMMELWEIS EGYETEM
Szemészeti Klinika

Igazgató
PROF. DR. NAGY ZOLTÁN ZSOLT

Informed Consent Form Version 1.2

Patient's Name: …..... ……
Date of Birth: .....
Telephone Number: ..... TAJ Number:.....
Diagnosis:..... .....

Administration of Ikervis (cyclosporine 1%) eye drops with the approval of the National Health Insurance Fund Administration (NEAK) and the National Institute of Pharmacy and Nutrition (OGYÉI).

I declare that I have shared with my treating physician all relevant information regarding my health status, including any past or current medical conditions, drug sensitivities, allergies, and previous surgical procedures.

I declare that I have received adequate information regarding the procedures involved in the examinations, as well as the expected outcomes and potential risks.

Based on the above information, I hereby consent to the ophthalmologist performing the ophthalmic examinations described above. Furthermore, I consent to ocular irrigation with physiological saline solution, if necessary, and to the recording of a short video for the purpose of tear film analysis.

Based on the above information, I hereby consent to the use of my clinical data and images by the treating physician for scientific purposes, including publication and presentation of the results.

I have read and understood the above statement, and all of my questions have been answered to my satisfaction by my treating physician.

Date:..... Signature: ….....

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