Ear, Nose & Throat specialty care

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Audiology and Hearing Aids

DISCLOSURE AND CONSENT

Medical and Surgical Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Dr. Kronenberger/Dr. Oxford/Dr. Lippert as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

CHRONIC AND/OR RECURRENT SINUSITIS

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures:

FUNCTIONAL ENDOSCOPIC SINUS SURGERY, WITH OR WITHOUT TURBINATE REDUCTION

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) do consent to the use of blood and blood products as deemed necessary.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

1. RECURRENCE OF ORIGINAL DISEASE PROCESS
2. CHANGES IN VISION – DECREASED VISION, DOUBLE VISION, OR BLINDNESS
3. DISCHARGE OF SPINAL FLUID FROM NOSE, POSSIBLY REQUIRING FURTHER SURGERY TO REPAIR
4. POSTOPERATIVE BLEEDING

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Signature_____DATE:_____/_____/_____TIME:_____ A.M. P.M.
PATIENT/OTHER LEGALLY RESPONSIBLE PERSON

WITNESS:

_____
NAME

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