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CONSENT FOR MYRINGOTOMY AND TYMPANOSTOMY

I, (patient or guardian) _____ hereby authorize Bassem M. Said, M.D.,
to perform (operation/procedure):

Myringotomy with tube placement (incision of ear drum and placement of small plastic tube to keep fluid from recollecting)

Alternatives to performing this procedure include: Observation, medical treatment.

Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Myringotomy with or without tympanostomy tube insertion is the most commonly performed ear operation. Potential complications are minor and usually in the form of infection, which may be treated with antibiotics. The tube usually remains in place for 6-12 months, although it may be rejected sooner or remain placed for years. Post-op care including water precautions are individualized and will be discussed by your physician. Occasionally the tympanic membrane fails to heal after tubes have been removed, and the resulting perforation may require surgical repair. In some cases, tympanostomy tubes may need to be replaced. Hearing improvement is usually immediate after fluid has been removed from the ear. Failure to improve hearing may indicate a second problem in the middle or inner ear.

Known potential adverse effects include: Tube could fall out prematurely and require additional procedures. Recurrence of fluid collections or infections requiring repeat procedures and treatment.

Anesthesia: I understand the act of delivering intravenous sedation and analgesia has benefits of relief and protection from pain, but carries no guarantees. Intravenous sedation also involves risks including infection or bleeding from needle sticks, damage to vessels and nerves (including paralysis), pneumonia, seizures, heart attack, stroke, adverse reaction (allergic reaction) and death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.

Additional Procedures: If my physician discovers a different unsuspected condition at the time of surgery, I authorize him to perform such treatment he deems necessary.

No Guarantee: I understand that no guarantee or assurance has been made as to the results of the procedure and it may not cure the condition.

Patient's Consent: I have read and fully understand this consent form. I understand I should not sign this form if my questions have not been answered to my satisfaction, or if I do not understand any of the terms or words contained in this consent form. I understand that I can withdraw this consent to the operation/procedure at any time before the beginning of the procedure/operation. *Do NOT* sign unless you have read and thoroughly understand this form.

Patient/Guardian Signature (state relationship)

Witness Signature

Patient/Guardian printed name

Witness printed name

Physician Declaration: I have explained to the patient/patient's representative the procedure/operation and the risks, benefits, recuperation, and alternatives (including the probable or likely consequences if no treatment is pursued.) I have answered all of the patient's questions and to the best of my knowledge, I believe the patient has been adequately informed.

Physician Signature