ENT & Audiology Center of Southlake

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DISCLOSURE AND CONSENT
TONSILLECTOMY AND ADENOIDECTOMY

THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical procedure to be used so that you can make the decision whether or not to undergo the surgery 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 that you may give or withhold your consent to the procedure.

I voluntarily request my physician, _____, to treat my condition which has been explained to me as:
Enlargement and/or infection of tonsils and adenoids with recurrent episodes of difficulty

I understand that the following surgical procedure is planned for me and I voluntarily consent and authorize this procedure:
Tonsillectomy and Adenoidectomy.

I understand that my physician may discover other or different conditions, which require additional or different procedures than are planned. I authorize said physician to perform such procedures, which are advisable in his/her professional judgment.

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

1. Post-operative bleeding
2. Dehydration from lack of fluid intake
3. Throat pain, possibly referred to ears.

I have been given the opportunity to ask questions about my condition, risks of no treatment, the surgical procedure to be performed, and the risks and hazards involved, and I have sufficient information to give this informed consent. I certify that this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been completed, and that I understand its contents.

_____ _____
PATIENT'S NAME DATE OF BIRTH

_____ _____
SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PARTY) RELATIONSHIP TO PATIENT

_____ _____ _____
WITNESS DATE OF SIGNATURE DATE OF SURGERY

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