# CONSENT FOR IN OFFICE ENDOSCOPIC SINUS SURGERY WITH BALLOON SINUS DILATION

BOISE ENT™

**Don J Beasley, MD**
**208-229-2368**

Sinusitis is an inflammation of the sinus lining. If the sinus opening becomes swollen shut, normal mucus drainage may not occur, and this may lead to infection and inflammation of the sinuses. Endoscopic sinus surgery aims to clear blocked sinuses and restore normal sinus drainage. The procedure removes bone and tissue to enlarge the sinus opening. The removal of bone and tissue may lead to pain, scarring, and bleeding.

The balloon devices are FDA-cleared, endoscopic, catheter-based instruments specifically designed to be used in sinus surgery. This technology utilizes a small, flexible, sinus balloon that is placed into the nose to reach the sinuses. It is gradually inflated to gently restructure the previously blocked sinus opening which helps to restore normal sinus drainage and function. There is minimal bleeding and many patients have been able to quickly return to normal activities. Other possible, but uncommon complications that can occur may include tissue and mucosal trauma, infection, or possible optic injury.

There may be alternatives to this procedure available to you such as treatment with antibiotics or topical nasal steroid sprays. However, at least 20% of patients do not respond adequately to medications. It is possible that the procedure may not help you or that you will be worse after the procedure than you were before. Because of these facts, your doctor can not guarantee as to the result that might be obtained from this procedure.

I certify that I have read or had read to me the contents of this form. I understand the risks and alternatives of this procedure. I have had the opportunity to ask any questions regarding the procedure and have all of my questions answered. I understand that I may call the office to ask additional questions if necessary.

☐ For the purpose of advancing medical education, I consent to the admittance of observers to the procedure room.

☐ I authorize my procedure to be photographed, filmed, or videotaped for any use.

☐ I do not wish to have my treatment or procedure photographed, filmed, or videotaped for any use.

Patient Name: _____ Account#: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____