CONSENT FOR ENDOSCOPIC SINUS SURGERY ETHMOIDECTOMY AND/OR NASAL POLYPECTOMY

BOISE ENT™

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Your doctor has recommended a procedure to correct an abnormality of your nose/ paranasal sinuses. The paranasal sinuses are air filled cavities that surround the nose. They are separated from the eyes and the brain by a thin layer of bone. The procedure is called endoscopic sinus surgery and it is performed using a lighted scope inserted through the nostrils for visualization. The procedure is usually performed to remove growths (polyps) from the nose and sinuses or to eliminate chronic infection of the sinuses.

Complications from this procedure are uncommon, however, they can occur. 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 make no guarantee as to the result that might be obtained from this procedure. However, in the majority of cases the desired result is achieved.

Some of the possible complications are: bleeding, meningitis, leakage of cerebral spinal fluid (the fluid surrounding the brain), eye damaged or blindness, injury to the carotid artery resulting in stroke or even death, injury to the tear duct system causing excessive tearing, numbness of the upper teeth and gums, damage to the olfactory nerves causing loss of smell, excessive crust formation after the operation, and allergic or adverse reactions to substances used during the procedure. Some of these potential complications can cause prolonged illness permanent disability, the need for blood transfusions and /or further surgery.

There may be alternatives to this procedure available to you such as the continued use of drug therapy. The alternatives carry their own risk of complications and carrying degrees of success.

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 all my questions have been answered.

☐ I consent to the photographing, filming, or videotaping of the treatment or procedure for educational and diagnostic use.

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

Signed: _____ Date: _____

Witness: _____ Date: _____

Patient account #: _____