First Hill
SURGERY CENTER

☐Left ☐Right ☐Bilateral Functional Endoscopic Sinus Surgery Consent Form

Patient Name: ______ Date of Birth: ______

Guardian Name (if applicable): ______ Patient ID: ______

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr. ____________________________ to perform a ☐Left ☐Right ☐Bilateral **Functional Endoscopic Sinus Surgery** upon me. I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to _____________.

I understand that the procedure or treatment can be described as follows:
Diseased tissue is removed from some or all of the sinuses including maxillary, frontal, ethmoid, and sphenoid sinus area.

This procedure will require anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Improvement of chronic dry cough, globus sensation, post nasal drainage, headache, and or loss of olfaction all which may improve in some individuals and not others.

3 MY RISKS

*I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.*

These could include but may not be limited to the following:

- Bleeding, infection, bleeding requiring a trip to the operating room, injury to the eye, loss of vision, injury to the fovea with leakage of spinal fluid into the nose requiring further surgery to repair it, persistent nasal congestion, persistent difficulty with recurring of a chronic infection or requiring antibiotics or even surgery, failure of low grade or significant anosmia or lost of smell to improve, to name the major factors.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4 MY CONSENT

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to intermittent antibiotics for infections as well as allergy consultation and treatment. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form.

I have read or had read to me and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed ☐Left ☐Right ☐Bilateral **Functional Endoscopic Sinus Surgery** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: ________________________________ **Date:** ______ **Time:** ________

Patient is unable to consent because ______________________. I therefore consent for the patient.
Authorized Consenter's Signature: ____________________________ Date: _______ Time: ______
Printed Name: ______________________________ Relationship to Patient: ____________________

☐ Mark this box if telephone consent

Witness Name: ____
PRINT NAME

Witness Signature: ______________________________ **Date:** ________ **Time:** _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: ____
PRINT NAME

Physician Signature: ____________________________ **Date:** ______ **Time:** _____