First Hill
SURGERY CENTER

☐Left ☐Right ☐Bilateral Placement of Pressure Equalization Tubes (PET) 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 ☐Left ☐Right ☐Bilateral **Placement of Pressure Equalization Tubes (PET)** 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:
Procedure involves making a small opening in the eardrum under the microscope, removal of any fluid discovered, and placement of a ear tube, bilaterally.

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:

- Ear tube placement attempts to relieve negative pressure, retraction of ear drum(s), ear effusion and/or recurrent ear infections, and/or hearing loss. The goal is unique for each patient.

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, persistent otorrhea requiring further treatment, displacement of the tube into the middle ear space requiring further surgery for extraction, persistent perforation requiring repair of the eardrum at a later date, the need to protect the ear from water while swimming with tubes in place, premature extrusion of the tubes requiring replacement in less than anticipated time (less than 1 month), prolonged retention of tubes requiring removal in the office or operating room, premature occlusion of the tube with blood and cerumen, resulting in need for second or greater number of tubes.

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 continued watchful waiting approach in the hopes that the infection or underlying fluid will resolve spontaneously. Treatment may include observational, serial audiograms, serial microscopic evaluation, antibiotics, and/or drops as indicated. These alternative forms of treatment have their own potential risks, benefits and possible complications. I understand that my physician is recommending a surgical treatment at this time.

I certify that I have read or had read to me the contents of this form 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 **Placement of Pressure Equalization Tubes (PET)** 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: _____