First Hill
SURGERY CENTER

Tonsillectomy/Adenoidectomy

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 consent for Dr. _____ to perform a **Tonsillectomy and/or Adenoidectomy** 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 **control infection and chronic obstruction.**

I understand that the procedure or treatment can be described as follows:
Tonsils and/or adenoids will be surgically removed to control infection and chronic obstruction.

This procedure requires general 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 surgery.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Removal of tonsils and/or adenoids may improve a recurring sore throat and/or recurring middle ear fluid, otitis media and sinusitis; chronic debris produced by tonsils and may decrease apnea in some individuals.

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, bleeding requiring a return trip to the operating room, postoperative infection, prolonged recovery, nasopharyngeal and/or oropharyngeal scarring, temporary or permanent derangement of taste, referred ear pain, dehydration, or weight loss due to discomfort.

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 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 treatment with medication and/or gargles in the place of surgery. 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 and will follow any patient instructions to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **Tonsillectomy and/or Adenoidectomy** 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:** _____