First Hill
SURGERY CENTER

Tympanoplasty 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 **Tympanoplasty 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

_____.

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: Removal of chronic infection/cholesteatoma, repair of tympanic membrane perforation, possible improvement of conductive hearing loss.

3 MY RISKS

*I understand that there are **potential risks, complications and side effects** associated with any 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 tinnitus in either ear, risks of reaction to anesthesia, facial nerve injury or paralysis, cerebrospinal fluid leakage, failed tympanic membrane graft, poor hearing outcome, need for further surgery, vertigo or imbalance, change in taste, anacusis or hearing loss. Inability to correct a conductive component of hearing loss due to diffuce tympanosclerosis. Inability to correct a sensorineural component of hearing loss.

- Ear Infection: with drainage, swelling and pain, may persist following surgery, or on rare occasions, may develop several days following surgery due to poor healing of the ear tissue. Sometimes, additional surgery might be necessary to control the infections.

- Loss of Hearing: In 3% of the ears operated on the hearing is further impaired permanently due to the extent of the disease or due to complications in the healing process; nothing further can be done in these instances.. On occasion, there is total loss of hearing in the operated ear, in some cases, a two stage operation in necessary. In the first stage, the ear disease is removed. In the second stage, the

middle ear bones are repaired in an attempt to improve hearing. The hearing is usually worse after the first operation.

- Tinnitus: Should the hearing be worse following the surgery, tinnitus (head noise) likewise may be more pronounced.
- Dizziness: May occur immediately following surgery due to swelling in the ear and irritation of the inner ear structures. Some unsteadiness may persist for a week postoperatively. On rare occasions, dizziness is prolonged.
- Taste Disturbance and Mouth Dryness: is not uncommon for a few weeks following surgery. In 5% of the patients, this disturbance is prolonged.
- Facial Paralysis: An uncommon postoperative complication of ear surgery is temporary paralysis of one side of the face. This may occur as a result of an abnormality or swelling of the nerve and usually subsides spontaneously. On rare occasion, the facial nerve may be injured at the time of surgery or it may be necessary to excise it in order to eradicate infection. When this happens a skin sensation nerve is removed from the upper part of the neck to replace the facial nerve. Complete paralysis of one side of the face under these circumstances might last six months to a year and there would be permanent residual weakness. Eye complications requiring treatment by a specialist could develop.

Complications related to Mastoidectomy:

- Hematoma: A hematoma (collection of blood under the skin incision) develops in a small percentage of cases, prolonging hospitalization and healing. Re-operation to remove the clot may be necessary if this complication occurs.
- Cerebral Spinal Fluid Leak: (leak of fluid surrounding the brain) is a very rare condition. Re-operation may be necessary to stop the leak.
- Intracranial (brain) Complications: such as meningitis or brain abscess, even paralysis, were common in cases of chronic otitis media prior to the antibiotic era. Fortunately, these are now extremely rare complications.
- Complications Related to General Anesthesia: are very rare, but can be serious. You may discuss these with the anesthesiologist if you desire.

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 **Tympanoplasty 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:** _____