CONSENT FOR MEDICAL TREATMENT AND SURGICAL PROCEDURES
TONSILLECTOMY AND ADENOIDECTOMY

TO THE PATIENT:  You have the right, as the patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Removal of tonsils and/or adenoids is one of the most frequently performed throat operations. It has proven to be a safe and effective surgical method to resolve breathing obstructions, throat infections, and manage recurrent childhood ear disease. Pain following surgery is an unpleasant side effect, which can be reasonably controlled with medication. It is similar to the pain patients have experienced with throat infections, but often is also felt in the ears after surgery. There are also some risks associated with removal of tonsils and/or adenoids. Postoperative bleeding occurs in about 2% of cases, most often immediately, although it can occur at any time during the first two weeks after surgery, there may be poor oral intake of fluids. If this cannot be corrected at home, the patient may be admitted to the hospital for IV fluid replacement. Anesthetic complications are known to exist; they are quite uncommon, however since patients are usually young and healthy. (Reprint from American Academy of Otolaryngology-Head and Neck Surgery)

I (we) voluntarily request Dr. __________________________ as my physician, and such associates, technical assistants, and other health care providers as they deem necessary, to treat my condition which has been explained to me as RECURRENT TONSIL INFECTIONS, ENLARGED TONSILS, ENLARGED ADENOIDs AND/OR CHRONIC EAR INFECTIONS.

I (we) understand that the following surgical procedures are planned for me and I (we) voluntarily consent and authorize TONSILLECTOMY AND ADENOIDECTOMY.

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician to perform such other procedures which are advisable in their professional judgment.

Just as there may be risks in continuing my present conditions without treatment, there are also risks and hazards related to the performance of the surgical procedures planned. I (we) realize that with all surgical procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction, and even death.

I (we) have been given an opportunity to ask questions about my condition including alternative forms of anesthesia and treatment, risk of nontreatment, the procedures to be used, and risks and hazards involved. I (we) believe that I (we) have sufficient information to give this informed consent. I (we) certify that I (we) read it or have had it read to me.

_________________________                                __________________________
Signature of Patient                                             Signature of Parent or Legally Responsible

_________________________                                    __________________________
Witness                                                        Relationship