DENTMD
EAR / NOSE / THROAT

Dr. Stephen Dent, M.D.

Turbinate Reduction

INFORMED CONSENT

Patient name: _____ Date: _____

1. I hereby request and authorize Dr. Dent, aided by any assistants he may require, to perform a turbinate reduction.

2. Dr. Dent has fully explained in terms clear to me, the effect and nature of the operation(s) to be performed, the foreseeable risks involved, alternative methods of treatment including not operating and not treating at all, as well as what I can expect to experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask questions and that these questions have been answered to my satisfaction.

3. The risks that I was specifically advised of included: temporary or prolonged pain and swelling, discoloration and bruising about the face, the possible need to return to the operating room to control bleeding, the possibility of bleeding or infection; transient or permanent numbness in the region operated; the development of allergic reaction to medications used during the course of treatment; the possibility of dissatisfaction with the results of the procedure; and the fact that healing takes longer in some patients than in others. I was also informed of the risks of stroke, heart attack and pulmonary embolus (blood clots in the lungs) and understand that in any operations, deaths have been known to occur from anesthesia, that the function of such organs as the brain, eyes, ears, lungs, intestines, kidneys, etc., have been adversely affected, and that paralysis of the limbs or other parts of the body can occur. I understand that all incisions (surgical cuts) heal with scar tissue, and that this healing process can result in poor (unsightly) scars even when the procedure was performed well.

4. I also authorize the operating surgeon to perform any other procedures that he may deem necessary or desirable in attempting to achieve the desired result of the procedure(s) or the elimination of unhealthy or unforeseen conditions that he may encounter during the procedure(s).

5. I consent to the administration of anesthesia by Dr. Dent and the use of such anesthetics and medications deemed advisable in my case.

6. I have been advised that the objective of the operation(s) I have requested is improvement, not perfection, that there is a possibility that imperfections might ensue, and that the result might not live up to my expections or the goals that have been established. I know that the practice of medicine and surgery is not an exact science and that, therefore, reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation(s) that I have herein requested and authorized.

7. I understand that Dr. Dent and his staff will make every effort to ensure a pleasing surgical outcome. I also realize that individual healing cannot be assured and that imperfections may ensue. Futhermore, I have been advised that minor revision procedures sometimes prove necessary and that I may incur additional financial responsibility for expenses not under the direct control of Dr. Dent.

8. I hereby give my permission by Dr. Dent or any assistant he may designate to take photographs or electronic images for diagnostic purposes, and to enhance the medical record. I agree that these photographs will remain their property. I further authorize them to use such photographs for teaching purposes or to illustrate scientific papers, books or lectures, if, in their judgement, medical research, educations, or science will be benefited by their use. It is specifically understood that in any such publications or use I shall not be identified by name.

9. I agree to follow the instructions given to me by Dr. Dent to the best of my ability, before, during, and after the above-mentioned surgical procedure.

Signature of patient/person authorized to give consent Date

Signature of witness Date