



INFERIOR TURBINATE REDUCTION INFORMED CONSENT

An inferior turbinate reduction is a procedure performed to reduce the turbinate size and thereby decreasing airway resistance while preserving the natural function of the turbinates. This should improve nasal breathing and may reduce nasal drainage and postnasal drip.

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.

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).

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 expectations 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.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I have sufficient information to give this informed consent. I certify this form has been fully explained to me, and I understand its contents. I understand every effort will be made to provide a positive outcome, but there are no guarantees.

Print Name: _____

Signature: _____

Date: _____