

DRS. GEHRIS, JORDAN, DAY & ASSOCIATES, LLC

Head and Neck Surgery . Ear, Nose and Throat Surgery . Facial Plastic & Reconstructive Surgery

Otolaryngology – Head and Neck Surgery

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CONSENT TO SURGERY

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. Operations or Procedure: **DIRECT LARYNGOSCOPY AND BIOPSIES (DL & BX)**

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be: (Description of operation or procedure in layman's language)

To use rigid metal scopes to look into the oral cavity, back of throat, and voice box region for any abnormalities and to take one or more biopsies of these regions. Risks include bleeding, infection, loss of airway, perforation through the airway, injury to the teeth, missed lesion, and future surgery.

which is to be performed under the direction of Dr. _____.

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are thought to be necessary or desirable, in the judgment of the professional staff of the below named medical facility, during the course of the above named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional of the below named medical facility.

4. Exceptions to the surgery or anesthesia, if any, are: _____
(If "None", so state)

5. I request the disposal by authorities of the below named medical facility of any tissue or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that various personnel undergoing training or indoctrination at this or other facilities may view them. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/NURSE PRACTITIONER: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

SBE Prophylaxis (Yes) (No) _____

Signature of Counseling Physician/Nurse Practitioner

2. PATIENT: Did you read this form? Yes No, Did you understand this form? Yes No, Do you have any questions? Yes No

The nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness)

(Signature of Patient)

(Date & Time)

3. SPONSOR OR GUARDIAN: (When a patient is a minor or unable to give consent) I

Sponsor/Guardian of _____ understands the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

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