

# DRS. GEHRIS, JORDAN, DAY & ASSOCIATES, LLC

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

Otolaryngology – Head and Neck Surgery

C. W. Gehris, Jr., M.D., FACS

T. E. Jordan, M.D., FACS

K.V. Day, M.D.

C.M. Lawson, M.D.

L.R. Proctor, M.D.

T.M. Clark, C.R.N.P.

D.F. Gagne', C.R.N.P.

General Plastic & Reconstructive Surgery

T.E. Jordan, M.D., FASC

Audiology

D.D. Allen, M.S., FAAA

S.N. Domzalski, M.S., CCC-A, FAAA

A.C. Waite, M.S., CCC-A, FAAA

K. Garson, AuD, CFY

## CONSENT TO SURGERY

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

### A. IDENTIFICATION

1. Operations or Procedure: **FUNCTIONAL ENDOSCOPIC SINUS SURGERY, POSSIBLE SEPTOPLASTY AND TURBINOPLASTY**

### 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 correct the septal defects and reduce the size of the turbinates, and to open the sinuses to relieve obstruction, promote drainage, and reduce infection. Risks include bleeding, infection, septal perforation, anosmia (total loss of the sense of smell), ozena (a chronically dry and infected nasal cavity), nasal obstruction, worsening of obstruction, spinal fluid leak possibly leading to meningitis, brain abscess and death, visual changes including blindness, tear duct injury, failure, worsening of symptoms or disease, 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:

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

I understand 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.

Upper Chesapeake Medical Campus  
520 Upper Chesapeake Drive  
Suite 206  
Bel Air, MD 21014  
Tel. 410-879-9100  
Fax 410-879-0227

Orchard Square  
1212 York Road  
Suite C202  
Lutherville, MD 21093  
Tel. 410-821-9110  
Fax 410-821-0321

421 South Union Avenue  
Havre de Grace, MD 21078  
Tel. 410-939-1819  
Fax 410-939-7094

Franklin Square  
9103 Franklin Square Drive  
Suite 302  
Baltimore, MD 21237  
Tel. 410-879-9100