INFORMED CONSENT FOR NASAL AND SINUS ENDOSCOPY AND CAUTERY OF NOSEBLEED

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

_____ _____

PATIENT'S NAME DATE

In addition to the requirements of Georgia law, the following consent is also intended to improve communication with and education of patients. The following has been explained to me in general terms and I understand that:

1. The DIAGNOSIS requiring this procedure: Nosebleed (epistaxis), undiagnosed mass.

2. The NATURE of this procedure: A procedure using telescopes to examine the inside of the nose and possibly inside the sinuses. Biopsy may also be needed.

3. The PURPOSE of this procedure: To attempt to eliminate bleeding in the nose and/or sinuses. To attempt to diagnose the patient's medial condition.

4. The MATERIAL RISKS of this procedure: As a result of this procedure being performed there may be material risks of infection, allergic reaction, disfiguring scar, severe loss of blood, loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, brain damage, cardiac arrest, or death.

   OTHER POSSIBLE RISKS: It is impossible to truly list all of the complications that may occur from any surgery. However, risks listed here have been carefully considered. In addition to the material risks listed above, there may be other possible risks involved in this procedure including but not limited to:

   POSSIBLE RISKS of anesthesia: Aspiration (breathing in of blood or mucus), pneumonia, loose or broken teeth, cardiac arrhythmias (irregular heartbeat), hoarseness, phlebitis, corneal abrasion, nosebleed, hyperthermia (abnormally high body temperature), electrolyte abnormalities (blood chemistry imbalance). Please discuss these with your anesthesiologist. I consent to the administration of anesthesia under the direction of the Anesthesia Associates of Rome, and will be advised by them about the risks of anesthesia, and the use of such anesthetics as they deem advisable. I understand that the administration of anesthesia is an independent function from surgery and the responsibility of this rests with the anesthesiologist.

   POSSIBLE RISKS of this procedure:

   a) Continued bleeding
   b) Blood loss necessitating transfusion which carries the risk of exposure to AIDS, hepatitis or other infectious diseases
   c) Need for additional surgery

d) Formation of adhesions and/or scar tissue in the nose or sinus openings
e) Septal perforation (a hole in the nasal septum)

5. THE LIKELIHOOD OF SUCCESS of this procedure is:
( ) good ( ) fair ( ) poor

6. THE PRACTICAL ALTERNATIVES to this procedure include:

a) Continued use of nose sprays
b) Cautery without telescopes
c) Posterior nasal packing

7. PROGNOSIS; If the patient chooses not to have the above procedure, the patient's prognosis (future medial condition) is:

a) Continued bleeding
b) Blood loss necessitating transfusion which carries the risk of exposure to AIDS, hepatitis or other infectious diseases
c) Need for more extensive surgery if site of bleeding not determined
d) Sinus infection if nasal packing is continued
e) Possible toxic shock syndrome if packing remains in nose to control bleeding

I understand that the physician, medical personnel or other assistants will rely on statements about the patient, the patient's medial history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition in recommending the procedure which has been explained.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the person described herein to make the decision concerning such procedures. I also consent to and authorize the performance of such additional procedures as deemed necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, X-Ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein.

I also consent that any tissues or specimens removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or health care provider.

I consent to the presence of observers in the operating room for medical, scientific or educational purposes approved by my physician.

I consent to the taking and publication of any photographs or video tapes during the course of the patient's operation or procedure for medical, scientific or educational purposes approved by my physician.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FROM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDESTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OR WERE STRICKEN BEFORE I SIGNED THIS FORM. I ASLO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERALS LISTED BELOW, RELATED TO THE PROCEDURE DESCRIBED HEREIN.

I voluntarily consent to allow Dr. _____ or any physician designated or selected by him and all medical personnel under the direct supervision and control of such physician, and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

Please answer the following questions by circling YES or NO:

(1)	Have you read the above document?	YES	NO
(2)	Do you understand the nature, expected benefits and risk of the above described surgical procedure as well as alternative treatment options?	YES	NO
(3)	Do you have a copy of this document?	YES	NO
(4)	Are you satisfied that all your questions have been answered?	YES	NO
(5)	Do you understand that there are no guarantees to surgical outcome?	YES	NO

_____ _____

Witness Patient or person giving consent

_____

Relationship to patient if not the patient

_____

Patient is unable to sign because of

_____

Additional materials used, if any, during the informed consent process for this procedure includes

_____

Patient or person giving consent