CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Dr. Marsha Reuther and such physicians, associates, assistants, and other personnel or the hospital or medical facility chosen by her to perform the following (in medical terms known as):
bilateral endoscopic sinus surgery with image guidance, bilateral inferior turbinate reduction, possible septoplasty

and/ or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- GENERAL RISKS AND COMPLICATIONS. I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this form. These risks include the risk " of bleeding, infection, pain, anesthesia risks and death.

- SPECIFIC RISKS AND COMPLICATIONS. I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):
pain, bleeding, infection, persistent symptoms, no improvement, toxic shock syndrome, tooth and nose numbness and pain, septal perforation (hole in septum), spinal fluid leak from nose, atrophic rhinitis (dry nose), alteration of sense of smell and taste, persistence and/ or worsening of facial pain, change in resonance or quality of voice, blindness, anesthetic risks, need for additional procedures, unforeseen complications

- ALTERNATIVE METHODS OF TREATMENT. I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):
no surgery, medical treatment, observation

- NO TREATMENT. I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

- SECOND OPINION. I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

- ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT. I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

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- OTHER SERVICES. I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.
- PHOTOGRAPHY. I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.
- NO GUARANTEES. I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.
- OTHER QUESTIONS. I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE: _____ TIME: _____

PRINT PATIENT NAME: _____

SIGNATURE: _____
(Patient, Parent, or Legal Guardian)

Translated By (if applicable): _____

Physician: _____

Witness: _____

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