

Informed Consent for Tonsillectomy and Adenoidectomy

Introduction

This information is given to you so that you can make an informed decision about having tonsillectomy and adenoidectomy. Take as much time as you wish to read this information and ask questions of your doctor or the assistants. You have the right to ask questions about and understand the surgery as well as you can before deciding to have the surgery. After learning of your condition and your options for treatment, you and your doctor are the ones who decide together if and when you should have this operation based on your needs and medical condition. This surgery is not an emergency. You may decide not to have this operation at all.

Nature of the Condition and Treatment

Except in unusual circumstances, tonsillectomy and adenoidectomy is appropriate when you have chronic tonsillitis, obstructive sleep apnea, or enlarged tonsil and adenoids causing problems with sleep, swallowing, sinus drainage, nasal breathing, or bad breath. If you choose to have tonsillectomy and adenoidectomy, it is important to understand that your tonsils (at the back of the mouth on both sides) and possibly your adenoids (at the back of the nose) will be permanently removed.

1. **Complications of Surgery in General:** As with all types of surgery, the possibility of other complications exists due to anesthesia, drug reactions or other factors which may involve other parts of my body, including a possibility of brain damage or even death. The likelihood of these complications is very low. The benefits of decreased infections and improved sleep and breathing from successful surgery are significantly greater than the possibility of a complication noted below.
2. **Specific Complications of Tonsillectomy and Adenoidectomy:** Risks include bleeding (potentially life-threatening) at time of surgery or after surgery (typically one week after), post-operative infection, severe pain, dehydration, loss of airway, pulmonary edema (fluid in lungs), need for hospitalization, unusual scarring of soft palate and back of mouth, velopharyngeal insufficiency (problems sealing off the back of the nose causing voice and swallowing problems), damage to lips and teeth, and need for further procedures.

Alternative Methods of Treatment for Chronic Tonsillitis and Adenotonsillar Enlargement

Alternative treatments for this condition are antibiotics when infected, steroids to decrease enlargement, airway support during sleep such as CPAP, and other techniques.

Patient Statement and Consent for Operation

I hereby authorize Matthew C. Jepsen, MD, and any associates or assistants of his choice to perform upon me tonsillectomy and adenoidectomy.

I recognize that during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those explained. I, therefore, further authorize and request my doctor and any associates or assistants of his choice perform such as are, in their professional judgment, necessary or appropriate for such procedures.

I understand that the proposed care may involve risks and possibilities of complications, and that certain complications have been known to follow the procedure to which I am consenting even when the utmost care, judgment and skill are used. I acknowledge that no guarantees have been made to me as to the results of the procedure, nor are there any guarantees against unfavorable results.

I accept the risks of substantial and serious harm, if any, in hopes of obtaining desired beneficial results of such care and acknowledge that the physicians involved have explained my condition, the proposed health care, and alternative forms of treatment in a satisfactory manner.

The basic procedures of the proposed surgery, the advantages, disadvantages, risks, possible complications, and alternative treatments have been explained and discussed with me by my doctor. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction. In signing this consent form, I am stating I have read this form (or it has been read to me), and I fully understand it and the possible risks, complications and benefits that can result from the surgery. I also acknowledge that the doctor has addressed all of my concerns regarding this surgery.

Patient's Name: _____ Age _____

Patient's Signature: _____

Date: _____ Time: _____ Place: _____

Witness' Signature: _____

Doctor's Signature: _____

As parent, guardian, caretaker, next of kin or other legal representative responsible for the patient whose name appears above on the appropriate patient signature line, I have read this document and, to the limit of the patient's understanding, I have discussed this informed consent and its terms with the patient. Due to the patient's inability to sign this informed consent, I agree, on behalf of the patient, to sign for the patient and bind him/her to the terms of this informed consent.

Name: (printed) _____

Signature: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Date: _____ Time: _____ Place: _____

I have received a copy of this informed consent for my own records. I have had the opportunity to read this informed consent and my questions regarding the surgery, alternatives, risks, and expected outcomes have been answered.

Signature: _____

Name: (printed) _____

Patients Name: _____

NOTE: You need to make a choice about receiving these health care items or services.

Your insurance company may not pay for the item(s) or service(s) that are described below. Insurance companies only pay for covered items and services when insurance company rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. Right now, in your case, your insurance company may not pay for –

Items or Services: T&A
Because: Your Deductible Patient Responsibility Not covered with your contract Out of network doctor or facility Pre-Existing condition Elective or cosmetic surgery

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why your insurance company may not pay.

<p><u> </u> Option 1. YES. I want to receive these items or services. I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company and understand that you may bill me for items or services and that I may have to pay the bill while the insurance company is making the decision. If my insurance company does pay, you will refund to me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally either out of pocket or through any other insurance that I have. I understand I can appeal the insurance company decision.</p>
<p><u> </u> Option 2. NO. I have decided not receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.</p>

Date

Signature of patient or person acting on patient's behalf