

TONSILLECTOMY

The tonsil is either of a pair of prominent masses of lymphoid tissue situated at the back of the throat. The tonsils act as filters to protect the body from invasion of bacteria and aid in the formation of white cells. In the operation of tonsillectomy, the tonsils are removed from the back of the throat. After surgery, the number of throat infections may be reduced but not completely eliminated.

Patient/Legal
Representative's
Initials

- _____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.
- _____ Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me.
- _____ I understand and accept that the most likely material risks and complications of tonsillectomy have been discussed with me and may include but are not limited to:
- *throat and ear pain*
 - *infection*
 - *bleeding*
 - *injury to the uvula (soft palate)*
 - *voice change*
- _____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
- _____ I understand and accept the risks of blood transfusion(s) that may be necessary.
- _____ I understand that bleeding after a tonsillectomy can be serious and that, should I experience bleeding, I will immediately call my doctor or go to the emergency room.
- _____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.
- _____ I have informed the doctor of all my known allergies.
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
- _____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
- _____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, MD, with associates or assistants of his or her choice, to perform tonsillectomy on _____ at _____.

(patient name) (name of facility)

Continued

I further authorize the physician(s) and assistants to do any other procedures that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

Physician Signature/Date/Time

initial copy given to patient

initial original placed in chart

SAMPLE