Department of Health
Government of Western Australia

CONSENT FORM
FOR
CORTICAL MASTOIDECTOMY

Med Rec. No.……………………………………………………………

Surname:……………………………………………………………

Forename: …………………………………………………………

DOB:…………………………………………………………………

AFFIX LABEL HERE

PROPOSED TREATMENT

The doctor has explained that **I**, *(name of patient)* ……………………………………………………………….,

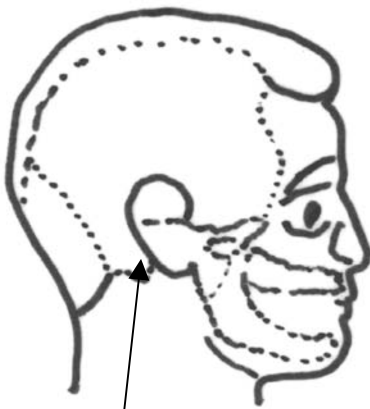
have ………………………………………………………………………………………………….and that

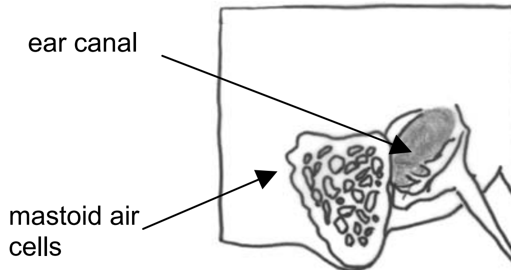
a **cortical mastoidectomy** on the …………………side is proposed:

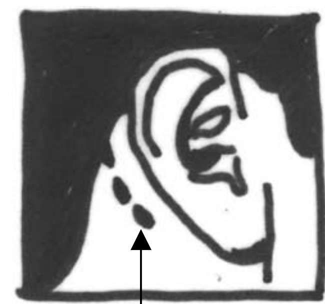
This means removing air cells found in the mastoid bone just behind the ear because they have become inflamed or infected.

Under a general anaesthetic, the surgeon opens the mastoid bone using a cut behind the ear or by going through the ear. The diseased cells are then removed. The ear drum is cut to allow infection behind to drain out and antibiotics are placed directly into the ear.

The wound may be closed around a small plastic drainage tube, which is removed after a few days. A large pressure dressing is applied, which is changed in a few days.







RISKS

These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your ENT surgeon if you have any general or specific concerns.

I understand there are risks associated with any **anaesthetic** *(see separate Anaesthetic Consent Form).*
I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand the procedure has the following **specific risks and limitations**:

- Although my hearing may not be improved, in many cases the operation will help to preserve my hearing.
- The operation may not improve my condition, and there is a small possibility I may have more severe symptoms afterwards.
- My wound may bleed after the operation and in some cases, I may need to return to the operating theatre for further surgery.
- My wound may become infected, with pain, redness and possibly a discharge. This may require antibiotics, or I may need another operation to help clear the infection.
- My wound may continue to drain fluid for some time.
- Uncommonly, the infection may spread to my brain or its coverings (meningitis).
- Uncommonly, my facial or other nerves may be damaged, leading to changes in taste, in sensation over the earlobe, temporary or permanent weakness of the muscles of the face, dizziness or changes in hearing.

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RISKS CONTINUED

- Rarely, the facial nerve, which runs very close to the operation site, may be damaged. This may result in numbness, and pain over half of my face on the operation side and weak or paralysed facial muscles. This may improve with time, or it may be permanent.
- Rarely, nerve damage during the operation can cause me to become deaf.
- My ear may look different after the operation
- I may notice dizziness, ringing in the ear or other unusual sensations in the ear afterwards. These are uncommon and usually temporary.
- I may have temporary loss of taste over part of my tongue on the same side as the operation.

I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

INDIVIDUAL RISKS

I understand the following are possible significant **risks and complications specific to my individual circumstances,** that I have considered in deciding to have this operation:

……

……

DECLARATION BY PATIENT

- I acknowledge the ENT surgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the ENT surgeon any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my ENT surgeon during this operation.
- I consent to a **blood transfusion,** if needed *(patient to circle and initial choice)* **YES** **NO**
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I understand that a doctor other than the specialist ENT surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If a needlestick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.

Signature of patient		**Date**	

If the patient is an adult and unable to give consent, a proxy form must be completed and attached

DECLARATION BY DOCTOR

- I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature			
Doctor's name *(please print)*		**Date**	

INTERPRETER'S DECLARATION - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's signature		**Date**	