



**CONSENT FORM  
FOR  
DIRECT LARYNGOSCOPY**

Med Rec. No.....

Surname:.....

Forename: .....

DOB:.....

AFFIX LABEL HERE

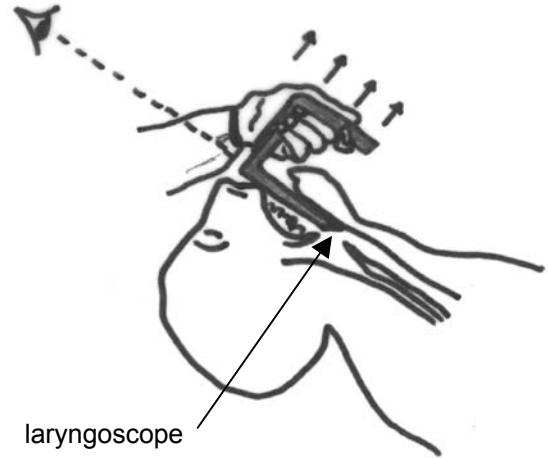
**PROPOSED TREATMENT**

The doctor has explained that I, (*name of patient*) .....,  
have .....and  
that a **direct laryngoscopy** is proposed:

**This means looking directly at the voice box (larynx) using a telescope.**

**If any tissue abnormalities are found, a tiny piece may be taken for detailed microscopic examination to help make the diagnosis.**

**Under a general anaesthetic a rigid telescope (laryngoscope) is used to inspect the voice box. If necessary, a microscope can be used to look at the vocal folds and other parts of the larynx under higher magnification.**



**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**:

- I may have some temporary pain or numbness of my tongue for a short while afterwards
- I may have some bruising of my lips which will settle in a few days
- Rarely, one of my teeth may be chipped
- If a tissue sample is taken, I may have small amount of bleeding afterwards.

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:

.....

.....

.....

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**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 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 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

Interpreter's name