



**CONSENT FORM
FOR
STAPEDECTOMY**

Med Rec. No.....

Surname:.....

Forename:

DOB:.....

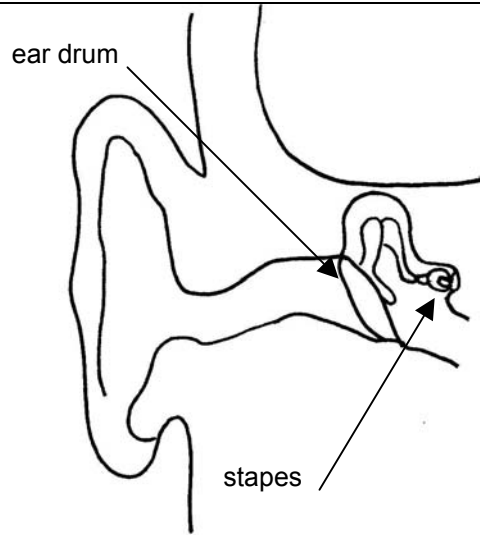
AFFIX LABEL HERE

PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*)
have **otosclerosis** (hearing loss due to bone hardening affecting the hearing mechanism) and that a **stapedectomy** on theside is proposed:

This means replacing the fixed stapes bone by a prosthesis that can move and therefore transmit sound vibrations to the inner ear to restore hearing. This is a quality of life, elective, procedure. You do not need it to live a normal life span and a hearing aid is an alternative solution.

Usually under a general anaesthetic, the surgeon lifts the ear drum and, using an operating microscope, removes the diseased stapes bone. A prosthetic replacement is put in place and the ear drum replaced. The ear drum is held in place by an absorbable packing ointment or a gelatin sponge.



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**:

- The operation is successful in most cases, giving improved hearing. However in a few cases, the improvement is less than hoped for and in a very few cases, my hearing may be worse than before the operation.
- I am likely to feel dizzy for the first few days, but this should improve over a few days.
- I may notice a metallic taste or loss of taste sensation over part of the side of the tongue on the side of the operation. This usually improves with time.
- I may have a perforated eardrum.
- With time, the prosthesis may fail, with the return of my hearing problems.

Uncommonly any of the following may occur:

- I may become completely deaf on the operated ear.
- I may have permanent dizziness; if severe, this may require further surgery.
- I may have persistent ringing in the ear (tinnitus) on the operated side.
- My face may be permanently weak or paralysed on the operated side.

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.

RISKS CONTINUED OVERLEAF →

**CONSENT FORM
FOR
STAPEDECTOMY**

Med Rec. No.....
Surname:.....
Forename:
DOB:.....

AFFIX LABEL HERE

RISKS CONTINUED

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 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 **Date**
(please print)

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
(please print)