



**CONSENT FORM  
FOR  
TONSILLECTOMY  
± ADENOIDECTOMY**

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

AFFIX LABEL HERE

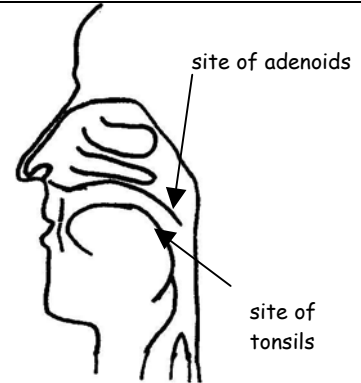
**PROPOSED TREATMENT**

The doctor has explained that I, (*name of patient*) ....., have the following condition:..... and that **tonsillectomy with/without adenoidectomy** (*delete as appropriate*) is proposed:

**This means removing all or part of the ring of tissue in the back of the throat, formed by the tonsils and adenoids.**

**Under a general anaesthetic, the mouth is propped open, then each tonsil or adenoid in turn is grasped with an instrument and dissected free from the underlying tissues.**

**The bleeding is stopped and any secretions are sucked out from the mouth and throat. As there is a risk of late bleeding (see below) I may be required to stay in the metropolitan area for two weeks after the operation.**



**RISKS**

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

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 that this procedure has the following **specific risks and limitations**:

- I may have some temporary difficulty breathing due to a blocked airway from blood clot or swelling.
- I will have regular pain relief and should be able to drink and eat reasonably comfortably. If I do not drink freely, I may become dehydrated and may be more likely to get infection in the wound.
- Bleeding may occur soon after the procedure, or between 5-14 days, when the wound scar tissue separates. Occasionally, a further operation is necessary to control the bleeding, and rarely a blood transfusion is required.
- I may get some ear pain after the operation and again around 5-7 days afterwards.
- I may still get sore throats from time to time, due to other causes.
- I may have a nasal quality to my speech after adenoidectomy due to palatal insufficiency. I may also have some regurgitation.

**INDIVIDUAL RISKS**

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

.....  
.....

MR CONSENT FORM FOR TONSILLECTOMY ± ADENOIDECTOMY (adult)

**CONSENT FORM  
FOR  
TONSILLECTOMY  
± ADENOIDECTOMY  
(CONTINUED)**

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

**DECLARATION BY PATIENT**

- I acknowledge the 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 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 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 unable to consent, a proxy form must be completed and attached*

**DECLARATION BY DOCTOR**

- I declare that I have explained to the parent(s)/guardian the nature of the patient's condition, the procedure to be performed, and discussed the risks that particularly concern the patient.
- I have given the parent(s) or guardian an opportunity to ask questions and I have answered these.

Doctor's signature:  Date

Doctor's name   
(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)