STEPHEN A. LANDERS, M.D.
DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY

PEDIATRIC AND ADULT
EAR, NOSE & THROAT

ENDOSCOPIC SINUS SURGERY

CONSENT FOR SURGERY
I hereby authorize Stephen A. Landers, M.D. to treat the following condition(s):

RECURRENT SINUS INFECTION AND/OR NASAL POLYPS

The procedures planned for the treatment of my condition(s) have been explained to me by my physician and are listed below:

ENDOSCOPIC SINUS SURGERY

Patient Information:

Endoscopic sinus surgery is performed intranasally and is recommended only after it has been determined that medical management has been unsuccessful. Surgery, medical management, and failure to intervene all have risks, including postoperative bleeding, orbital complications (visual impairment), intracranial extension (brain damage or infection), leakage of cerebrospinal fluid, persistent or recurrent nasal obstruction due to failure to manage polyps, and recurrent nasal or sinus infections.

Radiographs and endoscopic findings considered in conjunction with the patient's clinical status following medical evaluation and therapy would identify the appropriate sinuses to treat.

Known potential adverse effects include:

Failure to resolve the sinus infections or recurrence of sinus problems and/or polyps. Bleeding. Chronic nasal drainage or excessive dryness or crusting of the nose.
Need for further and more aggressive surgery.
Need for allergy evaluation, treatments, or environmental controls.
Failure to improve or resolve concurrent respiratory illness such as, but not limited to, asthma, bronchitis, or cough.
Failure to resolve associated "sinus or nasal" headaches.
Pain or numbness of the upper teeth, palate, or face.
Failure to restore or worsening of the sense of smell or taste.
Damage to the eye and its associated structures (extremely rare).
Damage to the skull base with resultant meningitis, brain abscess, or leakage of spinal fluid (extremely rare).

I/We have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedure to be used, and I/we have sufficient information to give this informed consent.
I/We certify this form has been fully explained to me/us, and I/we understand its contents.
I/We understand every effort will be made to provide a positive outcome, but there are no guarantees.

_____Date_____Time_____
Patient/Legal Guardian

Name(print)_____Witness_____

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