

Informed Consent for ENT Surgical Procedure

Patient Name:

Date of Birth:

Hospital/Facility:

Procedure Name:

Physician/Surgeon Name:

Description of Procedure

Indication for Surgery

Potential Benefits

Potential Risks and Complications

Alternative Treatments/Procedures

Additional Information/Comments

I acknowledge that I have had the opportunity to ask questions and that all of my questions have been answered to my satisfaction.

Signatures

Patient/Guardian Signature

Date

Physician/Surgeon Signature

Date