Mitchell Ramsey, M.D.
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GLACIER
ENT & HEARING

Hannah M. Sims, Au.D. CCC-A
Kay Lynn Benko, M.S. CCC-A
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Otolaryngology ● Head and Neck Cancer Surgery ● Nasal & Sinus Surgery ● Allergy
Thyroid & Parathyroid Surgery ● Audiology ● Facial Plastic and Reconstructive Surgery

Surgical Explanation and Consent: Surgery of the Middle Ear, Ear Canal, Ear Drum, and/or Mastoid

I understand that I am scheduled to undergo a surgery of the middle ear, ear canal, ear drum, and/or mastoid.

This surgery is typically done to decrease ear infections, remove abnormal growths in the ear, or help the ear function better. The surgery may be done for other reasons.

The surgery has inherent risks, which can occur during or after surgery. If they occur, they are typically temporary. Risks of this surgery include, but are not limited to,

- Bleeding
- Infection
- Pain and fever
- Numbness of the ear and/or tongue (this is expected for several months after surgery)
- Buildup of fluid or swelling at the surgical site
- Facial weakness or facial paralysis
- Injury to the facial nerve
- Alterations in taste
- Hearing loss, deafness, vertigo, changes in balance
- Hole in the ear drum
- Continued ear infections
- Bad scarring
- Failure to achieve the goals of surgery
- Need for further treatment and/or surgery
- Death, disability, dissatisfaction

Signature on the reverse side indicates that I have read and understand the above information, and I have had an opportunity to ask questions. I would like to proceed with surgery.

_____ (initials)

Two Medicine Building ● 160 Heritage Way ● Kalispell, MT 59901-3191
(406) 752-8330 ● Fax (406) 752-8412
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As you are aware there is a national COVID-19 pandemic. Logan Health has endorsed and followed CDC recommendations to mitigate potential exposure of the COVID-19 virus. However, there still can be an unforeseen risk of exposure. You understand this risk and agree to proceed with your scheduled visit/procedure.

PATIENT INFORMED CONSENT/REFUSAL

(Delete and initial any portions below which DO NOT apply)

I hereby request/refuse Healthcare Provider _____, and/or associates or assistants to perform the following procedure(s)/treatment(s): Surgery of the Middle Ear, Ear Canal, Ear Drum, and/or Mastoid

_____

I recognize that, during the course of the procedure(s), unforeseen conditions may necessitate additional or different procedures than those set out in the paragraph above. I, therefore, further authorize and request that my healthcare provider, his/her assistants, associates, technicians or other of their designees, perform such procedures as are in my healthcare provider's professional judgment, necessary and desirable including, but not limited to, procedures involving pathology and radiology. The authorization granted under this paragraph shall extend to remedying or repairing conditions that were not known to my physician at the time the procedure(s) commenced.

I further permit my Healthcare Provider to produce appropriate photograph(s) of the above procedure(s), treatment(s), and permit such photograph(s), in which I am not identified, to be used for medical education purposes. I consent to the taking of videotaped images to record treatment progress. I consent to the admittance of students, healthcare employees in the performance of their job, and others involved in the delivery of healthcare services, for purposes of education.

I fully understand that there is no guarantee that this procedure / treatment will improve my condition. I have been informed of my diagnosis, the purpose of the recommended procedure, the risks of the procedure, the alternatives to the procedure, the risks involved with the alternatives, and the probable outcome.

I understand that Logan Health is asking my permission to retain some of my tissue and body fluids ("specimens") that are collected during the procedure/treatment after all necessary tests have been performed. These specimens will be stored in a safe and secure location, which is called the Logan Health Tissue Archive. My specimens will be used only for my care and treatment at Logan Health. If I give my consent, my specimens will be kept as long as they remain useable, the tissue archive is active, or until I decide to withdraw my consent. I agree that Logan Health will contact me to obtain my written consent before my specimens may be used for any other purpose. I can change my mind and withdraw my consent at any time by contacting my Healthcare Provider. If I do not consent, or withdraw my consent, my specimens will be disposed of in accordance with standard practice.

Consent for Surgical Resident Participation in Procedure

1. I have been informed that a Surgical Resident will be present during the procedure and under the direct supervision of the attending Healthcare Provider n/a, the Surgical Resident will perform all or parts of the procedure.
2. I understand the attending Healthcare Provider will be present at all times in a directly supervisory capacity and the attending Healthcare Provider remains the responsible doctor for my procedure.

I consent to the utilization of a Surgical Resident in the performance of my procedure.

Healthcare Provider _____ has explained the above to me and I understand and I have no further questions.

☐ I **accept** the above procedure/treatment. Patient Signature_____

Printed Name _____ Date _____ Time_____

☐ **I refuse the above procedure / treatment and I agree to hold the hospital and my healthcare provider harmless for not performing the procedure/treatment.**

Patient Signature_____

or if the patient is unable to sign: Printed Name _____ Date _____ Time_____

Legal Representative _____Date _____ Time_____

Relationship To Patient _____Printed Name _____

Witness to Signature Only _____Date _____ Time_____

Printed Name _____

****

I have discussed the procedure/treatment with the patient including the following and answered all questions:

- **Diagnosis**
- **Purpose of the procedure**
- **Risks of the procedure**
- **Alternatives to the procedure**
- **Risks involved in the alternatives**
- **Probable outcome**

Healthcare Provider Signature _____ Date _____ Time_____

Printed Name _____

LOGAN HEALTH
Kalispell, Montana

PATIENT INFORMED CONSENT/REFUSAL

PATIENT LABEL