AUTHORIZATION & CONSENT FOR SURGERY

1. I,_____, authorize DAVID JETMORE, M.D. / ROHIT BAWA, M.D. / W. TIMOTHY HIRONS M.D., to perform the following procedure(s):

   **HEMI-LARYNGECTOMY / PARTIAL LARYNGECTOMY / SUPRAGLOTTIC LARYNGECTOMY / TRACHEOSTOMY / TOTAL LARYNGECTOMY, POSSIBLE NECK DISSECTION**

2. I understand the general nature of the health condition. The nature and effects of the operation including the expected outcome, the risks and complications involved, as well as alternative methods of treatment or management including no intervention have been fully explained to me by the Doctor and I understand them.

   RISKS & EXPECTATIONS: Any procedure involves some risks and hazards. The risks can include but are not limited to infection, bleeding, scarring, allergic reactions and even blood clots, heart attack, and pneumonia. These risks can be serious and potentially fatal. The significant and substantial risks of this particular procedure include: *Bleeding and infection are possible, but infrequently encountered. Incisional scars are uncommonly encountered and may require revision surgery. Numbness around the skin incision is usually temporary but could uncommonly be permanent. Weakness of the tongue or shoulder can occur. Difficulty breathing secondary to swelling around the neck is a risk. Swallowing problems may occur including aspiration into lungs with eating. Speech problems may be associated with any laryngectomy procedure. A possibility of further surgery may be encountered.*

3. I authorize the Doctor to perform any other procedure which he may deem necessary in attempting to improve the condition stated above or any unhealthy or unforeseen condition that may be encountered during the operation.

4. I consent to the administration of local anesthetics or sedatives by the Doctor or his assistant.

5. I consent to the disposal by hospital authorities of any tissue or parts, which may be removed.

6. I understand that the use of anesthetic agents and techniques involve risks and hazards which may range from minor injury and discomforts to major complications including very rare reactions leading to death.

7. I understand that the practice of medicine and surgery is not an exact science and that reputable practitioners cannot guarantee results. No guarantee or assurance has been given by the Doctor or anyone else as to the results that may be obtained.

8. Regarding Cosmetic or Reconstructive Procedures – I understand that the two sides of the human body are not the same and can never be made the same.

9. I give permission to Dr. Jetmore, Bawa or Hirons to take still or motion clinical photographs with the understanding that such photographs remain the property of their medical corporation. If, in the judgment of the corporation, medical research, education, or science will be benefited by their use, such photographs and related information may be published and republished in professional journals or medical books, or used for any other purpose which the corporation may deem proper. It is specifically understood that in any such publication or use, I shall not be identified by name.

10. I am satisfied that all of my questions regarding the proposed surgery have been answered and understood by me.

11. I certify that I have read the above authorization, that I understand the words and terms contained in this consent form, that the explanations referred to therein were made to my satisfaction, that I fully understand such explanations and the above authorization, and that I have received a copy of the entire consent form as signed.

_____ _____

Witness Patient or person with authority to consent for patient

Date_____ Time_____

PHYSICIANS DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed, understands the procedure and risks involved, and has consented.

_____ _____

Physician's Signature Date