

James R. Gaul, M.D.  
Michael J. Kelleher, M.D.  
Daniel J. Kelley, M.D.

Patient's Name: \_\_\_\_\_

Soc. Security No. \_\_\_\_\_

Date of Surgery/Procedure: \_\_\_\_\_

I hereby request Drs. \_\_\_\_\_

To perform the following procedure on me: TYMPANOSTAMIES WITH OR WITHOUT TUBES

Diagnosis: SEROUS OTITIS MEDIA

Reason for procedure: \_\_\_\_\_

I understand there are risks involved in all procedures. These include but are not limited to infection, hematoma, hemorrhage, pneumonia, heart attack, stroke, urinary tract infections, nerve damage and/or even death. Other possible problems include: 3% RISK OF PERSISTENT

PERFORATION WITH TUBES

Treatments instead of procedure: ANTIBIOTICS

Chance of success of procedure: GOOD

What may happen if procedure is not done: CONDITION MAY PERSIST

I know that the explanation I have received does not list everything that could happen and that other problems may develop. I have had all my questions answered and the information I have received is enough for me to give permission for this procedure. I know that no guarantee of success can be given. I have read all of this consent form, or had it read to me, and I understand it. My signature is completely voluntary.

\_\_\_\_\_  
Patient signature Date

\_\_\_\_\_  
Closest Relative or Legal Guardian Date

\_\_\_\_\_  
MD signature Date

\_\_\_\_\_  
Witness Date