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: **INJECTION SNOREPLASTY**

Diagnosis: **PRIMARY SNORING**

Reason for procedure: **RELIEVE SNORING**

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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: **THROAT SWELLING, FAILURE TO DECREASE SNORING, SWALLOWING PROBLEMS, AND ALLERGIC REACTION.**

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Treatments instead of procedure: **THROAT SPRAYS, OTHER SURGERIES**

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Chance of success of procedure: **80%**

What may happen if procedure is not done: **CONTINUE TO SNORE**

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