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: **INTRATYMPANIC MEMBRANE INJECTION**

Diagnosis: **TINNITUS, DIZZINESS**

Reason for procedure: **TO REDUCE INFLAMATION OF INNER EAR**

_____

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: _____

_____

_____

Treatments instead of procedure: _____

_____

Chance of success of procedure: **ABOUT 60% - 70%**

What may happen if procedure is not done: _____

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