

JAMES R. GAUL, M.D.
MICHAEL J. KELLEHER, M.D.
DANIEL J. KELLEY, M.D.

Patient Name: _____

Soc. Security No.: _____

Date of the Surgery/Procedure: _____

I hereby request that Dr.: _____

perform the following procedure on me: INJECTION SNOREPLASTY.

Diagnosis: PRIMARY SNORING

Reason for the Procedure: RELIEVE SNORING

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 infection, nerve damage and/or even death. Other possible problems include:

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

Treatments Instead of the Procedure: THROAT SPRAYS, OTHER SURGERIES

Chance of Success of the Procedure: 80%

What May Happen if the 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

M.D. Signature Date

Witness Date

Consent injection snoreplasty 9-04