EASTERN SHORE
ENT & Allergy
ASSOCIATES, P.A.

Salisbury Office: (410) 742-1567
Berlin Office: (410) 641-4582
Cambridge Office: (410) 901-3433

Patient Name: _____

Soc. Security No.: _____

Date of the Surgery/Procedure: _____

I hereby request that Dr.: _____

perform the following procedure on me: INTRATYMPANIC MEMBRANE INJECTION.

Diagnosis: TINNITUS, DIZZINESS

Reason for the Procedure: TO REDUCE INFLAMMATION OF THE 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 the following: _____

Treatments Instead of the Procedure: _____

Chance of Success of the Procedure: ABOUT 60 TO 70%

What May Happen if the 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
M.D. Signature	Date	Witness	Date

Consent Intratympanic Membrane 9-04