12319 N Mopac Expy, Bldg C, Suite #300, Austin, TX 78758-2403 (512)454-0341

Consent For Eustachian Tube Dilation

I hereby authorize Dr. Patrick Slater to treat (left, right or both) Eustachian tube(s) using an endoscopic balloon dilation device. The physician explained that the device used to perform this procedure is a commercially available product.

Dr. Patrick Slater has explained that common symptoms of ETD include ear pressure, fullness in the ear, dizziness, painful ears, crackling and popping sounds in the ears, tinnitus, muffled hearing, and pain or discomfort with barometric changes (e.g. flying, diving). Satisfactory treatment of ETD is achieved by dilating the Eustachian tube(s) improving its ability to regulate pressure in the ear(s). The general nature of the Eustachian tube endoscopic balloon dilation procedure for treatment of (the left, right or both) ear(s) has been explained to me. I understand that the known risks of this procedure include, but are not limited to:

*Pain
*Continued or worsening symptoms
*Carotid artery damage
*Bleeding
*Patulous Eustachian tube

I am aware that in addition to the risks specifically described above, there are other risks that may accompany any surgical procedure, such as intra- and post-operative blood loss, infection, and scar formation in the Eustachian tube(s) and/or sinus opening, which may require additional medication or surgical intervention, as, determined by the physician.

Dr. Patrick Slater has not guaranteed either the results of surgery or freedom from potential complications. I have had sufficient opportunity to discuss my condition and proposed treatment with Dr. Patrick Slater and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent for treatment.

YOU MUST HAVE A DRIVER WITH YOU AT THE TIME OF YOUR PROCEDURE. YOU ARE NOT ALLOWED TO DRIVE THE ENTIRE DAY OF YOUR PROCEDURE.

Patient Name (Printed):____Date:______________

Signature:____

Witness:____Date:______________