Hayley Jackson Health and Ear Care Clinic

Micro Suction/irrigation Ear Wax Removal Consent Form

Full Name _____*

Email Address_____

Address _____*

_____

Postcode_____ *

Contact Number _____*

Date of Birth_____ *

Name of GP Surgery _____*

Which ear do you need Wax Removal?

Left Ear/Right Ear/Both Ears

Do you suffer from any condition that causes balance problems or vertigo attacks? Yes/No

Have you suffered from any pain in your ears within the last 30 days? Yes/No

Do you have a perforated ear drum? Yes/No

Have you tried to remove the ear wax yourself? Yes/No

Are you currently under ENT consultant or receiving any treatment regarding your ears? Yes/No

Are you currently using any anti-coagulants? E.g. Warfarin *--Yes/No

Are you aware of any reason as to why you should not proceed with micro suction? Yes/No

Have you had Ear Wax removed from your ears previously? Yes/No

How did you come across our services?

Do we have your consent to send your GP a record of completion? Yes/No

Ear Wax Removal via Micro suction and irrigation is considered safer than other methods such as syringing. The ear wax removal will be carried out by our trained clinician. Complications of ear wax removal by micro suction and/or irrigation are uncommon; however possible complications, side-effects and material risk inherent in the procedure include, but are not limited to: incomplete removal of ear Wax requiring a return visit (for severely impacted wax), minor bleeding, discomfort, ringing in the ear (Tinnitus), perforation of the ear drum and hearing loss. To ensure the risk of complication is minimised, it is essential that accurate past medical history is supplied to our clinicians. In addition, it is important the patient remains relatively still during the procedure as sudden movement may significantly increase the risk of ear drum perforation, permanent hearing loss and/or bleeding.

By agreeing to the Terms and Conditions above, you accept that you have read and understand the possible complications that may occur and agree that H J Health & Ear Clinic or any of its employees, cannot be held responsible for these. I have read and understood these terms and conditions and am willing to be bound by them.

Statement of Consent:

I understand that personal information is held about me.

I have had the opportunity to discuss the implications of sharing or not sharing information about me.

Customer signature_____Date_____

Therapist signature_____ Date_____