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 suffer from Tinnitus?

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

Do you have any allergies? 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 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.

I have read and understood the terms and conditions ☐

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.

Client signature_____Date_____

Therapist signature_____ Date_____

Data Protection

I agree to provide Alison Lee with my address and contact details, as well as details pertaining to my medical history (inclusive of current medications that I take). I understand that these details are essential to Alison Lee being able to safely tend to my treatment needs. I understand that these personal details will be processed by Alison Lee and will only be accessible to Alison Lee who acts as data processor along with the other practitioners working within the HJ Health clinic. I understand that my details will not be passed on to any third parties.

I agree that in the event of a medical emergency, my GP can be contacted and that any emergency services may access my clinical records in such an event. I understand that my details will be retained for a period of up to 7 years after my last appointment (or the date of my 25th birthday if my last appointment was attended whilst I was under the age of 18) before they will be destroyed. By signing this agreement I provide consent for ongoing treatment in line with my clinical needs. Treatments will be explained to me by Alison Lee and that I will seek clarity from Alison Lee if I am in any doubt/have any concerns related to this treatment.

I understand that in the unlikely event that I suffer a minor injury during a treatment then there are some simple precautionary steps that ought to be taken. I understand that it is possible that the injury could become more serious unless I take appropriate care. Any such incident will always be recorded at the time. I agree that if I feel that there has or may have been any injury as a result of a treatment then I will ensure that I notify Alison Lee at the time and will seek Alison Lee's advice on any aftercare precautions that may be necessary. If I am in any doubt as to whether I have suffered an injury, I will consult Alison Lee. I accept that if I do not notify Alison Lee at the time, then it may be impossible to identify the cause of an infection or injury and too late to take simple precautionary steps Alison Lee &H J Health will not be responsible for the consequences of a failure by a patient to immediately notify any possible injury.

Client signature_____Date_____

Therapist signature_____ Date_____