

## **Ear Irrigation Consent**

	Patient Name: Da	te of Birth:	_	
	Street Address:			
	Town: P		_	
	Contact number: Mobile:		_	
	Email:		_	
	G.P. Name and address:			
	Please inform your practitioner if you have or I			
		Yes	No	
)	Have you had ear syringing before?			
)	Any previous problem following irrigation?			
)	Any current or previous perforation of the ear drum? If so when?			
)	A cleft palate?			
)	Are you immunocompromised or suffer from diabetes?			
6)	Any previous ear surgery including grommets? If so when?			
)	Do you wear hearing aids?			
)	Any discharge or ear infection within the past 6 weeks?			
)	A foreign body in the ear?			
0)	Any pain in your ears or mastoid tenderness?			
1)	Do you usually have hearing in one ear only?			
2)	Do you have or have suffered from Vertigo			
	(feels like you or the environment is moving or spinning around).			
3)	Tinnitus (ringing in the ears). Is this recent or longstanding?			
4)	Have you oiled your ears daily for at least 7 days?			
5)	Have you had a recent head injury?			
6)	Are you on any anticoagulants (blood thinning) medication?			

• Failure of wax removal

- Ear Infection
- Perforation of the ear drum
- Pain / discomfort
- Dizziness
- Increase of pre-existing tinnitus
- Bleeding

## **CONSENT FOR EAR IRRIGATION**

I confirm I have read the above information, the www.patient.co.uk information leaflet on ear wax I was emailed or posted and the Simply Fox information sheet I was emailed or posted. The information I have given is correct and I am aware of the possible risks of ear syringing. I have been fully informed of the procedure and consent to the procedure being carried out. I have asked any questions I wish to before signing this consent form.

Signed Patient	Print Name	Date	
Signed Practitioner	Print Name	Date	
Ears Syringed	Y/N		
Left	TM intact Y /N		
Right	TM intact Y/N		
Any complications or concerns.			
Referral necessary	Y/N		
Prescription issued	Y/N Advice to buy Ear	Calm Y/N	