External Ear Meatoplasty / Canalplasty

**A Patient’s side** left / right or N/A

**Consultant or other responsible health professional**

**Name and job title:**

☐ Any special needs of the patient (e.g. help with communication)?

**Please use ‘Procedure completed’ stamp here on completion:**

**B Statement of health professional** (details of treatment, risks and benefits)

1 I confirm I am a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the hospital’s consent policy. I have explained the procedure to the patient. In particular, I have explained:

   a) the intended benefits of the procedure (please state)

   - Increase size of ear canal
   - Improve wax clearance
   - Prevent further ear canal / mastoid cavity infections

   b) the possible risks involved. Addenbrooke’s always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

   - Bleeding
   - Infection
   - Pain
   - Numbness of ear
   - Scar
   - Ear dressing reaction

   c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
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d) any extra procedures that might become necessary during the procedure such as:
   ☐ Blood transfusion  ☐ Other procedure (please state)

2 The following information leaflet has been provided:

External ear meatoplasty/canalplasty

Version, reference and date:  Version 3, CF476, November 2017
or ☐ I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:
   ☐ General and/or regional anaesthesia  ☐ Local anaesthesia  ☐ Sedation  ☐ None

Signed (Health professional):  Date: D.D./M.M./Y.Y.Y.Y.

Name (PRINT):  Time (24hr): H.H.:M.M.

Designation:  Contact/bleep no:

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.
   ☐ Yes  ☐ No

2 Photography, Audio or Visual Recording
   a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.
   ☐ Yes  ☐ No

   b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.
   ☐ Yes  ☐ No

3 Students in training
   I agree to the involvement of medical and other students as part of their formal training.
   ☐ Yes  ☐ No
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Use of Tissue
a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research. □ Yes □ No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records. □ Yes □ No

I have listed below any procedures that I do not wish to be carried out without further discussion.


I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ________________________________ Date: __/__/____
Name of patient (PRINT):

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.

Signed: ______________________________________ Date: __/__/____
Relationship to patient:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): ______________________________ Date: __/__/____
Name of witness (PRINT):
Address:

Patient safety – at the heart of all we do

Addenbrooke’s Hospital | Rosie Hospital

CF476 External ear meatoplasty/canalplasty version 2
September 2017
D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Name (PRINT): .............................................................................. Job title: ..........................................................

Please initial to confirm all sections have been completed:

E Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Name (PRINT): ..............................................................................

Or, please note the language line reference ID number:

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Signed (Health professional): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Name (PRINT): .............................................................................. Job title: ..........................................................