

Micro Suction Ear Wax Removal Consent For

To safely remove any wax or foreign bodies present within the ear canal, it is important the clinician is made fully aware of anything which may have a bearing on the procedure. Please answer the following questions regarding your hearing health by ticking and completing relevant boxes:

Do you suffer from any condition that causes balance problems or vertigo attacks?*

- Yes
 No

Have you had any fluid discharge from your ear/s within the last 30 days?*

- Yes
 No

Have you suffered any pain in your ears within the last 30 days?*

- Yes
 No

Are you aware of, or suspect you may have a perforated ear drum?*

- Yes
 No

Have you tried to remove the wax yourself other than using ear drops?*

- Yes
 No

Have you had any surgical operations on your ears, nose or throat?*

- Yes

No

Are you currently under an ENT Consultant or receiving any treatment regarding your ears?*

Yes

No

Are you using any antiplatelet or anticoagulant blood thinners?*

(E.g. Warfarin)

Yes

No

Do you have persistent tinnitus (usually a ringing or buzzing noise in the head or ears)?*

Yes

No

Have you had wax removed from your ears previously?*

Yes - micro suction

Yes - other

No

Are you aware of any reason as to why you should not proceed with micro suction?*

Yes

No

Patient Name:*

First

Last

Patient signature:*

(or signature of parent if under 16, guardian or attorney if appropriate)