



**STEPHEN A. LANDERS, M.D.**  
 DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY  
 HEAD AND NECK SURGERY

PEDIATRIC AND ADULT  
 EAR, NOSE & THROAT

**TONSILLECTOMY & ADENOIDECTOMY - CONSENT FOR SURGERY**

I hereby authorize Stephen A. Landers, M.D. to treat the following condition(s):

INFLAMMATION OF TONSILS AND ADENOIDS AND/OR ENLARGEMENT OF TONSILS AND ADENOIDS

The procedures planned for the treatment of my condition(s) have been explained to me by my physician and are listed below:

REMOVAL OF TONSILS AND ADENOIDS (TONSILLECTOMY AND ADENOIDECTOMY)

**Patient Information:**

Removal of tonsils and/or adenoids is one of the most frequently performed throat operations. It has proven to be a safe, effective surgical method to resolve breathing obstruction and throat infections, and manage recurrent childhood ear disease. Pain following surgery is an unpleasant side effect, which can be reasonably controlled with medication. It is similar to the pain patients have experienced with throat infections, but is often also felt in the ears after surgery. There are also some risks associated with removal of tonsils and/or adenoids. Postoperative bleeding occurs in about 2% of cases, most often immediately, although it can occur at any time during the first 2 weeks after surgery. Treatment of bleeding is usually an outpatient procedure, but sometimes requires control in the operating room under general anesthesia. In rare cases, a blood transfusion may be recommended. Because swallowing is painful after surgery, there may be poor oral intake of fluids. If this cannot be corrected at home, the patient may be admitted to the hospital for IV fluid replacement. Anesthetic complications are known to exist. They are quite uncommon, however, since patients are usually young and healthy.

Known potential adverse effects include:

- DIFFICULTY IN SWALLOWING
- POSSIBLE RECURRENCE OF INFECTION
- THROAT PAIN
- POSSIBLE TEMPORARY VOICE CHANGE
- POSTOPERATIVE BLEEDING OR HEMORRHAGE REQUIRING FURTHER PROCEDURES
- ALTERNATIVE THERAPY MAY INCLUDE: OBSERVATION, MEDICAL TREATMENTS

I/We have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedure to be used, and I/we have sufficient information to give this informed consent.

I/We certify this form has been fully explained to me/us, and I/we understand its contents.

I/We understand every effort will be made to provide a positive outcome, but there are no guarantees.

\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Patient/Legal Guardian

Name(print) \_\_\_\_\_ Witness \_\_\_\_\_

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