



CHANCELLOR PARK  
FAMILY MEDICAL PRACTICE  
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## EAR SYRINGING CONSENT FORM

Patient Surname: \_\_\_\_\_ Patient Address: \_\_\_\_\_  
Patient Given Names: \_\_\_\_\_  
Patient D.O.B \_\_\_\_\_  
Doctor Requesting Consent: \_\_\_\_\_

A) The doctor has explained that I have impacted earwax, debris or foreign material in my ear. The doctor has explained that the condition requires gentle syringing of the ear/s with warm water.

**B) Listed below are some of the potential complications of ear syringing:**

- Perforation of the tympanic membrane. Possibly leading to otitis media or secondary cholesteatoma. Failure of the perforation to heal may lead to the need for surgical repair of the tympanic membrane
- Bruising of the canal
- Ulceration of the Canal
- Bleeding from the ear
- Aggravation of otitis externa
- Malignant otitis externa
- Earache
- Onset or aggravation of tinnitus/hyperacusis
- Hearing loss
- Vertigo/nausea
- Facial palsy

C) I consent to the practice nurse performing this procedure

Yes  No

I consent to the doctor performing this procedure

Yes  No

The syringing will be performed on my:

R) ear  L) ear

**D) Acknowledgements**

**1) The Patient:**

I acknowledge that the doctor has explained the procedure and has answered any queries and concerns I have about this matter. I acknowledge that no guarantee has been made that the procedure will improve the condition.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**2) The Doctor:**

I declare that I have personally explained the nature of the patient's condition and the need for ear syringing, as well as the risks involved. I have given the patient an opportunity to ask questions which I have answered as fully as possible.

Signature of Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

**3) The Nurse:**

I declare that I have performed an Ear Syringe on the above patient to the:

R) ear  L) ear

Result and Comment: \_\_\_\_\_

Signature of Nurse: \_\_\_\_\_ Name of Nurse: \_\_\_\_\_ Date: \_\_\_\_\_