Hartford Hospital
A Hartford HealthCare Partner

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Authorization for Flexible Fiberoptic Laryngoscopy

Patient's Name: _____

I herby authorize Dr. _____ to perform the following special procedure/treatment: **Flexible Fiberoptic Laryngoscopy**

Fiberoptic laryngoscopy is a way for your doctor to look at your voice box (larynx) as well as other nearby structures in your throat (pharynx). This helps your doctor see if there is any visible cancer or other problems. I understand that this procedure may need to be repeated during and after a course of treatment. To do the procedure, a flexible tube about the width of a straw is put into the nose and threaded into the throat. The nose is usually numbed (anesthetized) before the tube is placed.

I understand that residents, medical students, physician assistants (PA) and/or other advanced practice registered nurses (APRN) may also be in attendance, and/or assisting in the performance, and/or performing significant medical/surgical tasks within the above specified special procedure/treatment. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed special procedure/treatment that require the assistance of other qualified medical personnel who have not been identified.

The following has been explained to me in connection with the proposed procedure/treatment: (i) the nature and purpose of the proposed procedure/treatment; (ii) the foreseeable risks and consequences of the proposed procedure/treatment, including the risk that the proposed procedure/treatment may not achieve the desired objective; and (iii), the alternatives to the proposed procedure/treatment and the associated risks and benefits to such alternatives.

Specifically, in obtaining my informed consent to this special procedure, I have been informed of the following reasonably foreseeable risks (less than 2-3% risk):

- Discomfort / pain
- Bleeding
- Gagging
- Sore throat
- Inability to see well so that cancer is missed

- Allergic reaction (rare) to the numbing medicine that could cause life-threatening problems

- Extremely rare side effect of swelling of the voice box (larynx) that could make breathing difficult or impossible and that could require an emergency tube placed below the voice box (tracheostomy)

I affirm that I understand the purpose and potential benefits of the proposed treatment and/or special procedure, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed procedure/treatment.

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I also authorize the Hospital and the above-named physician(s) to photograph, video and/or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

_____M. D. Signed: _____
(Patient or legally authorized representative)

Date: _____Time:_____ Date: _____Time:_____

Interpreter responsible for explaining procedures and special treatment:

_____ (Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [□] BECAUSE:

_____

_____ M.D. Date: _____Time:_____

_____ Witness Date: _____Time:_____