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Ear Microsuction Patient Consent Form

Patient Name: Date: 15/07/2026

Address:

D.O.B:

Part 1 Does the patient have capacity? Yes No Complete Part 1

Follow the Advance Care Directive (ACD), or if there is no ACD, obtain consent from the legal substitute medical treatment decision maker (MTDM). Category of MTDM _____

Name of substitute MTDM: _____

Part 2 Is an interpreter required? ❒ No ❒ Yes Complete Part 2

In-person or Telephone Language: _____

Name of interpreter: _____Signature (if in-person) _____

Part 3 Patient OR MTDM requests ear microsuction.

Clinician has explained the procedure, the risks associated with it and the alternatives.

Part 4a Clinical Indication / Details (tick all relevant):

❒ ***Itching sensation*** ❒ ***Feeling of fullness*** ❒ ***Hearing loss*** ❒ ***Impacted wax*** ❒ ***Tinnitus/other noises***

Part 4b Precautions identified:

❒ Middle ear pain or infection/mucus discharge

❒ Grommet R / L (current/past 18mths)

❒ Cleft Palate/Ear/mastoid surgery

❒ Past or current tympanic perforation

❒ Immunocompromised/infection risk (incl high dose steroids)

❒ Movement disorder/manageable restlessness/short memory

❒ Otitis Externa

❒ Unilateral hearing

❒ Vertigo

❒ Blood thinners

❒ Diabetes

❒ Sensitivity to noise

Details/other information: _____

Part 5 Ear drops (minimum 7 days for ear wax microsuction)

Clinician has explained how and when to administer wax softening ear drops, and provided the written Patient Information page with instructions.

Part 6 Costs for Ear Microsuction procedure

Fee payable: $136 or Pensioner $68
Our price is the same for the procedure, whether both or one ear is cleaned and/or proceedure does not proceed or is ceased for patient comfort +/- safety reasons not limited to patients inability to sit still, or is incomplete eg due to dryness of ear wax.
A second fee payable will be charged if a repeat booking is required due to inadequate patient preparation and insuficient use of softening drops or if a repeat/additional proceedure becomes clinically indicated

Part 7

I acknowledge that the clinician has explained the "Ear Microsuction" procedure and provided me with the Patient Information. I was able to ask questions and raise concerns with the clinician. They explained the possible risks, benefits and alternatives available, Including:

❒ **Potential Risks/side effects:**

- Rare risk of damage to ear canal (trauma/grazing the outer ear or structures)
- Rare risk of tympanic membrane perforation (rupture of the eardrum)
- Occasionally, incomplete removal of wax or foreign body
- Temporary vertigo (where a person feels as if they, or the objects around them, are moving when they are not, with dizziness/unsteadiness, nausea and or vomiting)
- Discomfort, pain and or a cough.

❒ I understand that:

- I have the right to change my mind (withdraw consent) at any time, including after signing this form.
- The out-of-pocket costs and know that a clinician other than the one consenting me might perform the treatment.
- The cerumen microsuction procedure requires wax softening with drops for 7 days prior.
- Many of the risks can be reduced by staying very still during the procedure. If I do need to move, I will tell my nurse (or raise my hand) so they can pause the procedure.
- It is better if I have my eyes open during the procedure.
- I should return to Andrew Place Clinic for assessment and possible treatment if I have concerns after my treatment.

I / MTDM have received the Patient Information titled 'Ear Microsuction'.

I agree to immediately tell the nurse (or raise my hand) during the procedure if I have **any** dizziness or discomfort, **and/or** if I have the need to move/cough: the procedure will pause.

Informed (as above), I consent to having ear microsuction.

Patient: **Patient signature:**_____
D.O.B:
Address:

or MTDM Name:_____ **Signature**:_____

Clinician: Signature: _____ ❒ RN ❒ DR Date: 15/07/2026