Lillypadcare@yahoo.com
07851 684297

Microsuction/Irrigation, Ear Wax Removal Consent Form

Full Name _____

Email Address_____

Address _____

_____

Postcode_____

Contact Number _____

Date of Birth_____/_____/_____

Which ear/s are causing you problems? Left Ear / Right Ear / Both Ears

Do you suffer from any condition that causes balance problems or vertigo attacks? Yes / No

Have you suffered from any pain in your ears within the last 30 days? Yes / No

Do you have or ever had a perforated eardrum? Yes / No

If yes how long ago? _____

Have you ever had surgery on your ears? Yes/No

If yes, what surgery and how long ago?_____

Have you tried to remove the ear wax yourself? Yes / No

Are you currently under an ENT consultant or receiving treatment regarding your ears? Yes / No

Are you currently using any anti-coagulants? E.g., Warfarin, Clopidogrel, Apixaban, Rivaroxaban, Aspirin, Etc? Yes / No

Have you had Ear Wax removed from your ears previously? Yes / No

How did you come across our services? _____

Ear Wax Removal via Microsuction/ Warm Water Irrigation is considered safer than other methods such as syringing. The ear wax removal will be carried out by one or more of our trained clinicians. Complications of ear wax removal are uncommon; however possible complications, side effects, and material risks inherent in the procedure include, but are not limited to; incomplete removal of ear Wax requiring a return visit (for severely impacted wax), minor bleeding, discomfort, ringing in the ear (Tinnitus), perforation of the eardrum and hearing loss.

To ensure the risk of complication is minimised, it is essential that accurate past medical history is supplied to our clinicians. In addition, it is important the patient remains relatively still during the procedure as sudden movement may significantly increase the risk of eardrum perforation, permanent hearing loss, and/or bleeding.

By agreeing to the Terms and Conditions above, you accept that you have read and understand the possible complications that may occur and agree that Lillypad Ear Wax Removal or any of its employees, cannot be held responsible for these. I have read and understood these terms and conditions and am willing to be bound by them.

Statement of Consent

☐ I have read and agree to the terms and conditions above and understand that personal information is held about me.

☐ I have had the opportunity to discuss the implications of sharing or not sharing information about me with my GP.

☐ I give permission for Lillypad Ear Wax Removal to contact me with offers and updates.

☐ I give permission for Lillypad Ear Wax Removal to send me text messages.

Full Name (capitals) _____

Signature_____

Date_____