



# Intake and Cerumen Removal Consent Form

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: Mr / Mrs / Ms / Miss / Dr \_\_\_\_\_

Birth Date (d/m/y): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Health Card #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Cerumen removal should only be attempted by a professional who has the necessary training and qualifications. Every precaution possible will be taken to avoid discomfort or adverse results during the removal procedure. Removal of the cerumen may entail using drops to soften the cerumen and extra ction by instrument, suctioning or rinsing with water.

**Possible associated risks with the procedure may include** injury to the ear canal that can result in some bleeding, perforation of the eardrum , damage to the small bones of the middle ear , tinnitus , dizziness/vertigo and nausea or failure to remove the blockage Some people may feel mild to moderate discomfort during the procedure.

**Please check all that apply:**

- Previous wax removal
- History of ruptured eardrum
- Ear infections
- Ear surgery
- Dizziness
- Ear drainage
- Pressure equalizing tubes

By signing this form of consent, you agree that you have been informed of the risks of cerumen management and agree not to hold the hearing professional or York Hearing Clinic liable if any injury may occur.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Notes: \_\_\_\_\_

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