Idaho Dysphagia Specialists

Providing mobile FEES to the patients of the Treasure Valley

INFORMED CONSENT FOR PROCEDURE

PATIENT NAME:_____ DATE:_____

FACILITY:_____ MR#:_____

I hereby permit _____ of Idaho Dysphagia Specialists, to perform Fiberoptic Endoscopic Evaluations of Swallowing (FEES) procedure.

I understand that this procedure appeared indicated by the diagnostic and/or clinical observations performed. I have been informed of the details of the FEES procedure, indications of the procedure with material risks and benefits, side effects, alternatives, intended goals and likelihood of the success of the procedure have been explained to me.

I authorize the administration of topic anesthetics and/or nasal decongestant if needed. I have been fully advised about, and understand, the nature and purpose of these medications, possible risks and complications.

I understand that I am not compelled to undergo FEES. I understand the procedure is designed to assist in the diagnosis of dysphagia, but no guarantees have been offered, either express or implied, as to the results of this procedure.

I have fully understand this consent form. I understand I should not sign this form if the treatment, the alternatives, and the risks and the benefits have not been explained to my satisfaction. I further understand that I should not sign this form if I have unanswered questions of if I do not understand any of these terms or words used in this consent. I will follow all recommendations concerning its usage to include lab testing, physical exams, and office visits at the recommended intervals.

I certify that I have been given an opportunity to ask any and all questions I have concerning the proposed treatment, and I have received all requested information and all questions answered. I fully understand that I have the right to not consent to the FEES procedure. I believe I have adequate knowledge upon which to base an informed consent and give this consent voluntarily.

_____ _____ _____

Signature of Patient *Initials* *Date*

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the proposed procedure to the patient. I have provided the patient an opportunity to ask questions and answered all questions fully. It is my professional opinion that the patient fully understands the information I have presented.

_____ _____ _____

Signature of Speech-Language Pathologist ***License Number*** ***Date***

Idaho Dysphagia Specialists, PLLC
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