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**CONSENT FOR OFFICE PROCEDURE**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_, authorize the following procedure:

- |  |   |
|--|---|
| _____ Nasal Endoscopy                    | _____ Incision & Drainage abscess or hematoma |
| _____ Laryngoscopy                       | _____ Needle Biopsy                           |
| _____ Esophagoscopy                      | _____ Aspirate abscess or cyst                |
| _____ Nasopharyngoscopy                  | _____ Allergy Testing                         |
| _____ Biopsy of a Skin or Mucosal lesion | _____ Cautery or packing of a nasal bleed     |
| _____ Excision of Skin or Mucosal lesion |   |

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.

X \_\_\_\_\_ / /  
Signature of Patient or Person Assuming Financial Res (if other than patient) Date

If Patient's Representative, signed on behalf of: \_\_\_\_\_  
Please Print Name of Patient Representative

Description of representative's Authority:

Attach documentation of legal authority, if Legal Guardian or Holder of Power of Attorney.

Witness: \_\_\_\_\_