

OTOLARYNGOLOGISTS AND  
OTOLARYNGOLOGY SURGEONS:  
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ALLERGY-IMMUNOLOGIST:  
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*Specializing in the treatment of diseases  
of the ear, nose, throat and sinus*

## CONSENT FOR TREATMENT/ PROCEDURE

I give my consent to Dr. \_\_\_\_\_Jonathan P. Lindman\_\_\_\_\_ to

Excision of keloid from your face/head and neck region(s)

(Name of treatment/ procedure. Description in lay & medical terms)

I am aware that, during the procedure, other procedures might be needed. I give my consent to do these procedures as needed.

I give my consent to receive anesthesia and/or medications that I may need. I know that all procedures and anesthetics have risks like stroke, heart attack, respiratory failure and death, but that these are exceedingly rare. The risks of keloid removal are minor. These include minor bleeding, infection, pain from the injection of the anesthetic and allergic reaction to the anesthetic, and scar. You also have a risk of the keloid redeveloping. To reduce the chances of this occurring, Dr Lindman recommends repeated injections of a steroid agent into the operated site(s). The tissue your doctor obtains from this procedure will be sent to the pathology department and we should have a report in about 1 week. There are no guarantees in medicine and so you must be aware that there is also a chance that you may require further surgery to achieve the desired result(s).

Dr Lindman may offer you immediate reconstruction or delayed reconstruction depending on your situation. This may require further surgery.

I know that each person reacts in a different way to treatments and procedures. Therefore, the results cannot be certain. My questions have been answered about the procedure. I have been told:

1. The treatment or procedure that my doctors plan to do
2. What to expect from the treatment or procedure (the benefits).
3. The serious risks of this treatment or procedure. Some of these risks can happen despite all steps being taken to prevent them.
4. Other types of treatment that could be used. This includes no treatment.
5. Whether or not the treatment or procedure is uncommon.

PATIENT NAME:

Health Care Provider obtaining consent (PRINT NAME & INITIAL) Debbie Driggers, LPN		SIGNATURE of person giving consent (legally authorized to do so)
DATE SIGNED	TIME	AM/PM
Relationship to patient (if applicable)		Second witness for telephone consent:
Name of interpreter:		