Stealth Energiser EAR MICRO SUCTION/IRRIGATION CARE PLAN

Surname						
Forename						
Email						
Address						
Telephone						
Date of Birth			NHS No.			
Date /Time						
GP						

1. Problem: Please document visible findings following examination of the ear (s) prior to procedure

Left Ear		

Right Ear		

2. Aim: To remove cerumen with ease and safety and assist in improving hearing

3. Intervention: Ascertain the following information prior to ear micro suction/irrigation. Please Yes or No and do not suction/irrigate if information provided is contra-indicated

- Has been instilling ear drops/oil
 Patient informed of potential risk of infection and injury, in particular perforation
- 3 Does the patient perceive to have reduced hearing due to wax
- 4 History of perforated tympanic membrane to affected ear(s)
- 5 Have there been any problems previously with ear microsuction/irrigation
- 6 Surgery to affected ear(s) including myringotomy (grommets), cleft palate and mastoid cavities
- 7 Excessive pain to affected ear(s)
- 8 Discharge other than waxy discharge/Inflammation
- 9 Giddiness, nausea, itching or headaches (please circle whichever applies)
- 10 Any foreign body in affected ears(s)
- 11 Any known allergies
- 12 Any past/current history of anticoagulants (If yes, monitor for bleeding following procedure)

-	t Ear	Right Ear			
Yes No		Yes	No		

4. Evaluation: Please document on the condition of the tympanic membrane and the external auditory meatus following irrigation and any follow-up advice/ treatment offered

Was Cerumen successfully removed? Yes or No _____

Left Ear			Right Ear
lam (Please)	~	Patient Parent Guardian	

I have had the procedure for ear microsuction/irrigation explained fully to me, have had the opportuity to ask any questions and give my consent to this procedure

Post irrigation/microsuction advice given and to seek medical advice, please contact your GP.

Patient's Signature	
Date	