

Name: _____

DOB: _____

FamilyCare

Cerumen Impaction Removal Note

Date: _____ Intake by: _____

Ear	Pre-procedure Dx	Pre-procedure Dx
L	<input type="checkbox"/> Cerumen Impaction (380.4)	
R	<input type="checkbox"/> Cerumen Impaction (380.4)	

Vital Signs	
BP _____	P _____
RR _____	T _____

The procedure was explained to the patient, including all risks, benefits, alternatives and potential complications. Verbal informed consent was obtained.

Left Ear:

- Impacted cerumen was identified blocking ear canal
- Using an ear curette a small moderate large amount of cerumen was removed _____ times by the provider
- Using an ear hook a small moderate large amount of cerumen was removed by the provider
- Using forceps a small moderate large amount of cerumen was removed by the provider
- External canal was lavaged with warm water
- No trauma to external ear canal during procedure
- Minimal trauma to external ear canal during procedure
- Antibiotic _____ was applied to canal

Right Ear:

- Impacted cerumen was identified blocking ear canal
- Using an ear curette a small moderate large amount of cerumen was removed _____ times by the provider
- Using an ear hook a small moderate large amount of cerumen was removed by the provider
- Using forceps a small moderate large amount of cerumen was removed by the provider
- External canal was lavaged with warm water
- No trauma to external ear canal during procedure
- Minimal trauma to external ear canal during procedure
- Antibiotic _____ was applied to canal

69210: Instrumentation was used to remove impacted cerumen. Removal required a significant amount of time

Post Procedure:

- Ear canal left right clear, normal TM
- Patient was requested to make a follow-up appointment in _____ days weeks months
- Patient tolerated the procedure well and there were no complications
- Verbal ear care instructions were given to patient or parent
- Written ear care instructions were given to patient or parent
- Patient was instructed to call the office if there are any problems or questions

Dictated note

Clinician Signature: _____

Name: _____

DOB: _____

FamilyCare

Please print this form CFG-0204-2.surg.prog.note as follows:

8.5 X 11 24# white paper

1 sided printing

reverse side is blank

black ink

no folding

2 holes punched centered at page top of page 2 standard for chart forms

This page is for information only. It is not to be printed

Questions please contact Bob Smithing at 253.852.7723