OTOPLASTY

Otoplasty is a surgical process to reshape the ear. A variety of different techniques and approaches may be used to reshape congenital prominence in the ear or to restore damaged ears, most of which involve surgically modifying the cartilage framework..

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform the otoplasty on _____.
(*patient name*)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient's Initials

_____ The details of the procedure have been explained to me in terms I understand.

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I understand and accept possible risks and complications include but are not limited to:

- *bleeding*
- *infection*
- *change of skin sensation*
- *ear trauma*
- *skin contour irregularities*
- *asymmetry*
- *allergic reaction to topical preparations*
- *pain*
- *scarring*
- *unsatisfaction results*

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with any surgical procedure.

_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring, but cannot control its ultimate appearance.

_____ I am aware that smoking during the 3-4 week pre- and postoperative periods is prohibited as smoking could dramatically increase chances of complications.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made or implied.

_____ I have been informed of what to expect post-operatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

____ Pre- and post-operative photos and/or videos will be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending physician.

_____ The doctor has answered all of my questions regarding this procedure.

_____ Plastic surgery is not an exact science. On occasion there are instances when revisional surgery may be required to obtain maximum desired results. There may be additional minor fees associated with a touch-up/revisional surgery. This is reviewed on a case-by-case basis.

I certify that I have read and understand the above and that all blanks were filled in prior to my signature.

Patient or Legal Representative Signature / Date	Relationship (self, parent, etc.)
Print Patient or Legal Representative Name	Witness Signature / Date

I certify that I have explained the nature, purpose, benefits, and alternatives to the proposed treatment and the risks and consequences of not proceeding, have offered to answer any questions and have fully answered all such questions. I believe that the ***patient / legal representative*** *(circle one)* fully understands what I have explained.

Physician Signature / Date

_____ copy given to patient
initial

_____ original placed in chart
initial