166 Pasadena Dr. Suite 100
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Lexington Plastic Surgery™

Theodore L. Gerstle, M.D.
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OTOPLASTY

REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT:_____ DATE:____/____/____

I understand that the above-named procedure has been explained and is to be performed on me.

The following has been explained to me in general terms and I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is prominent or misshapen ears.

2. The **NATURE OF THE PROCEDURE** is to reshape the ear(s) by modifying the ear skin and cartilage. This may involve removal, suturing or scoring of the cartilage to achieve a more normal configuration. For some circumstances, cartilage may need to be taken from some other area of the body and added to the affected ear(s). Sources of cartilage include the ribs, the nose or an unaffected ear. Incisions will be made on the ear to gain access to the cartilage and to further define the ear shape.

3. The **PURPOSE OF THIS PROCEDURE** is to attempt to give the affected ear(s) a more natural shape and/or size as well as create the best possible match between the two ears. The procedure will NOT restore hearing.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. There is not a good substitute for surgery. Sometimes ears may be reshaped by taping or molding in a newborn, but this does not work beyond approximately 6 weeks of age.

5. **IF I CHOOSE NOT TO HAVE THE ABOVE NAMED PROCEDURE, MY PROGNOSIS (future medical condition)** is not completely predictable and the medical condition may get better, may get worse or may stay the same. However, failure to have the procedure may result in possible progression of the medical condition and/or the possible need for more extensive surgery if the medical condition progresses and remains undiagnosed or untreated. Diet, exercise, pregnancy, aging and health problems may all contribute to future changes in my medical condition.

6. **MATERIAL RISKS OF THIS PROCEDURE:** As a result of this procedure being performed, there may be material risks of: INFECTION, ALLERGIC REACTION, TOXIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.

7. In addition to these material risks, there may be **OTHER POSSIBLE RISKS** involved in this procedure including but not limited to:

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1. overcorrection or under correction of one or both ears;

2. size or shape difference between the two ears;

8. **OTHER POSSIBLE RISKS (concluded):**

3. donor sites may not heal appropriately, resulting in unsatisfactory scars, deformity of the surrounding tissue, collapse of the lung (if rib cartilage is used);

4. improvement from surgery may change or be lost as time passes;

5. ear position on the head may not be ideal or the same on both sides;

6. the ear(s) may have ridges, irregular contours or sharp edges;

7. there may be temporary or permanent numbness;

8. a hematoma (blood clot or collections of bloody fluid) may occur at the operative site;

9. infection of abscess formation (collection of pus) may occur which may yield chondritis (cartilage infection). Treatment of severe infection may necessitate removal of cartilage grafts or existing cartilage as well as the need for skin grafts or flaps to cover exposed cartilage;

10. fluid collections may accumulate under the skin and may require drainage or aspiration (withdrawal by needle);

11. pain and discomfort may occur;

12. numbness (sensory loss, loss of feeling), itching, firmness, lumpiness and tight feelings may occur and could be temporary or permanent;

13. scars will occur and may go from pink and firm to faded and soft over a period of 6 to 12 months; some scars may widen, become depressed or appear raised, firm and "ropey" red which may take 2 years or longer to fade and soften; scars will be PERMANENT AND VISIBLE;

14. bruising and swelling may occur and last a few weeks to several months;

15. some tissue may slough (dissolve away) due to poor healing which may cause additional scars;

16. sutures in the ear(s) may work through the thin overlying skin over time and have to be removed;

9. Even though the risks and complications cited above are infrequent, they are the ones peculiar to the operation and are of greatest concern. Complications may also be increased due to my individual medical condition and personal habits. Medications, i.e. **ASPIRIN**, may interfere with blood clotting

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and cause excessive bleeding. **SMOKING CIGARETTES** may interfere with the blood supply to the skin and may cause abnormal healing with tissue slough (dissolving away) and excessive scarring. **ALCOHOL** may cause excessive bleeding during and after surgery. Certain **HERBAL PREPARATIONS** may affect the blood clotting system and cause excessive bleeding while others may inhibit healing of the incisions. Colds, infections, boils, and pustules may increase the risk of infection after surgery. Excessive sun exposure and/or tanning beds, heating pads and hot water bottles may cause severe burns at the surgery site if one has temporary or permanently lost protective sensation.

10. I understand that the physician, medical personnel and other assistants will rely on statements made by me concerning the medical history and other information I provide in determining whether to perform the procedure or the course of treatment for the condition and in recommending the procedure which has been explained to me. Withholding medical and/or health information may result in further complications.

11. There may be a need for immediate or other additional surgery to treat the above complications, which could include hospitalization, time off work and additional expense to me.

12. I understand that my expectations should be realistic, and I should consider not undergoing the surgery if my expectations are greater than the reality of this treatment. Psychological problems may occur due to unrealistic expectations of the surgery or difficulties in accepting changes in my appearance.

13. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE.

14. I consent to the taking of pictures during the course of my treatment for the purpose of helping to plan and assess the proposed therapy. No photographs will be shown to patients or physicians without my permission. If any portion of my surgery to be billed to insurance (this does not include cosmetic procedures), I understand my insurance carrier may require photographs to process my claim.

15. On occasion, surgical revisions may be indicated following the original surgery. If planned or performed within one (1) year after the original surgery, there will be no charge by the surgeon. However, a fee will be charged by the facility for use of the operating room. There will also be a charge by the anesthesiologist if indicated.

16. I voluntarily consent to allow Dr. Gerstle and all medical personnel under his direct supervision and control and all other personnel who may otherwise be involved in performing such procedures to perform the procedure(s) described or otherwise referred to herein.

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17. BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN.

Signature of person giving consent:_____Date:___/___/____

Relationship to patient if not the patient:_____

Witness:_____

_____Copy of consent form offered to patient

_____Copy given _____Declined

Initials _____