

NASAL RECONSTRUCTION (RHINOPLASTY)

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 an external nasal deformity, prominent nose, or unflattering nose. This may be from an inherited characteristic, birth, or injury. The shape and/or size of the nose may be undesirable to the patient. Sometimes the nose may be collapsed so as to interfere with the air passages. There may be a nasal septal deviation, which could block the space for air to pass.
2. The **NATURE OF THE PROCEDURE** is to attempt to reconstruct the nose surgically by an operation (called "nasal reconstruction" or "rhinoplasty") aimed at changing the shape and size of the nose to a more satisfactory balance with the rest of the face. This is done by incisions made inside and/or outside the nose and rearrangement of the bony and cartilaginous skeleton up under the skin so that the skin drape may assume a new shape as it conforms to the changed supportive structure. Sometimes it is necessary to take out skin at the sides of the base of the nose by the nostrils also. This would leave an outside scar, but it falls in areas of natural contours. Sometimes cartilage is borrowed from a place where it is dispensable and placed in the nose to improve contours and provide support. This is called a "cartilage graft".
3. The **PURPOSE OF THIS PROCEDURE** is to attempt to make the appearance of the nose more natural, and occasionally, when it is severely collapsed or blocked, to help open the nostril airways.
4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. Sometimes makeup may help a bit if very skillfully applied.
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. The condition may worsen or improve with changes of climate, allergic condition, and/or injury.
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, and 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:
 - 1) healing problems may occur which might result in a change in the shape of the nose or residual external deformity, asymmetry, or airway blockage;
 - 2) internal scarring or adhesions may occur;

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

- 3) a septal perforation (opening or hole in the nasal septum) may occur after surgery and cause irritative nasal symptoms (dryness or crusting) or a peculiar sound like a whistle;
 - 4) there may be persistent swelling in the nose, especially around the tip, that may be temporary, last several months or years, or may be permanent;
 - 5) a hematoma (blood clot or collections of bloody fluid) may occur at the operative site;
 - 6) severe blood loss may occur which may necessitate transfusion which carries the risk of exposure to AIDS, hepatitis or other infectious diseases;
 - 7) abscess formation (collection of pus) or sinusitis may occur;
 - 8) if cartilage grafts are used, they may resorb (dissolve), become displaced and result in an unusual position, or work their way out from underneath the skin, becoming exposed and necessary to be removed;
 - 9) if cartilage grafts are used, there may be a resulting perforation of the nasal septum (opening in the divider between the two air passageways) or potential ear deformity, depending on where the cartilage is taken from;
 - 10) some tissue may slough (dissolve away) due to poor healing;
 - 11) some fatty tissue may undergo fat necrosis (dissolve away) which may cause lumpiness or firmness in the tissue and may sometimes require drainage;
 - 12) fluid collections may accumulate under the skin and may require drainage or aspiration (withdrawal by needle);
 - 13) pain and discomfort may occur,
 - 14) numbness (sensory loss, loss of feeling), itching, firmness, lumpiness and tight feelings may occur and could be temporary or permanent;
 - 15) an injury to the tear duct may occur;
 - 16) if portions of the nostrils are removed to reduce the flair or an incision on the outside of the nose is required, scars will occur and may go from pink and firm to faded and soft over a period of six to twelve months; some scars may widen, become depressed, or appear raised and "ropey" red which may take two years or longer to fade and soften; scars will be PERMANENT AND VISIBLE.
 - 17) bruising and swelling may occur and last a few weeks to several months;
8. 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 the patient's individual medical condition and personal habits. Medications, i.e. **ASPIRIN**, may interfere with blood clotting and cause excessive bleeding. **SMOKING CIGARETTES** may interfere with the blood supply to the skin and may cause abnormal healing with tissue sloughing (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 temporarily or permanently lost protective sensation.

9. I understand that the physician, medical personnel and other assistants will rely on statements made by me concerning my medical history and other information I provide in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure, which has been explained to me. Withholding medical and/or health information may result in further complications.
10. 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.
11. 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.
12. 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.
13. 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 is to be billed to insurance (this does not include cosmetic procedures), I understand my insurance carrier may require photographs to process my claim.
14. On occasion, unplanned 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.
15. 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.
16. 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: _____ Date: _____

_____ Copy of consent form offered to patient

_____ Copy given _____ Declined