



## CONSENT FOR EAR SURGERY (OTOPLASTY)

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

**Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.**

I have been informed that I have the following condition(s): \_\_\_\_\_

The procedure(s) to treat my condition(s) has/have been described as: \_\_\_\_\_

1. Otoplasty is a form of ear surgery performed to change the appearance of disproportionately large or prominent ears by positioning them closer to the head.
2. Ear surgery may be performed under local anesthesia (numbing of the area), often in conjunction with pre-operative sedation, intravenous sedation or general anesthesia to help relieve anxiety.
3. I have been advised and I understand that there is no guarantee that ear surgery will improve my appearance or correct any pre-existing condition(s).
4. I have been completely honest with my doctor regarding my motivation for undergoing ear surgery and realize that a new appearance to my ears does not guarantee an improved life.
5. If I use tobacco, I agree to cease all use of tobacco for 2-3 weeks prior to and after surgery. Failure to do so may have serious negative effects on the success of my surgery.

### SURGICAL CONSIDERATIONS

6. Incisions will be made in the back of the ear and the skin opened to expose the ear cartilage that shapes the ear. The cartilage will then be surgically repositioned or reshaped in an attempt to improve appearance and function. The skin incisions will be closed with stitches. I have been told and understand that a residual scar behind the ear can be expected. In most cases, especially in children, the scar fades with time. However, the scar line may be permanent and, due to individual healing differences, may require an additional procedure (scar revision) to attempt to minimize its visibility.

### POST-OPERATIVE CONSIDERATIONS

7. After surgery the ear will be covered with a bulky pressure dressing. Some surgical discomfort can be expected and is usually controlled with medication. In rare cases, discomfort may be prolonged for several weeks. If surgery is done in a hospital, a stay of a few days may be required.
8. In a few days the bulky dressing will usually be removed, after which a light head dressing will be required for several weeks. The area may exhibit some swelling and bruising.
9. In some cases, as a result of the new ear position, the fold in the ear may appear more prominent.
10. Patients, particularly children, should refrain from excessive or strenuous physical activity such as lifting, heavy labor, swimming or sports activity for several weeks.

## RISKS AND COMPLICATIONS

11. My doctor has explained to me that there are certain inherent and potential risks in any surgery, and that in this specific instance such operative risks include, but are not limited to:
- A. Bruising, swelling and discomfort for an indeterminate time.
  - B. Residual or permanent scarring behind the ear.
  - C. Infection which may require antibiotics. In cases of severe infection, hospitalization and additional treatment may be required.
  - D. Bleeding is usually slight, but may occasionally be excessive, in which case additional treatment may be required. Very rarely, blood transfusions may be required, and I have been advised of my rights concerning donation of my own blood before surgery so it may be transfused back to me if necessary.
  - E. Asymmetry of the ears - one side may appear different from the other.
  - F. The operated ears may tend to return to their original position (relapse) requiring additional corrective surgery. This is a particular risk when careful attention is not paid to prescribed post-operative instructions.
  - G. In rare cases, a blood clot may occur at the site of surgery requiring drainage or a follow-up procedure.
  - H. Failure to follow post-operative instructions may increase the risk of any of the foregoing.
  - I. Some numbness of the skin of the ear may result. Usually it is temporary, but may rarely be permanent.

12. **ANESTHESIA**  
The anesthetic I have chosen for my surgery is:
- Local Anesthesia
  - Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
  - Local Anesthesia with Oral Premedication
  - Local Anesthesia with Intravenous Sedation
  - General Anesthesia

13. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage, or death.

14. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
  - B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
  - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
  - D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

## NO GUARANTEE OF TREATMENT RESULTS

15. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there is a risk of failure or relapse, my condition may worsen, and selective re-treatment may be required in spite of the care provided.
16. I have had an opportunity to discuss my past medical and social history, including drug and alcohol use, with my doctor and I have fully informed him/her of all aspects of my health history, recognizing that withholding information may jeopardize the planned goals of surgery.
17. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that any lack of cooperation can result in a less-than-optimal result, or may be life-threatening.
18. If any unforeseen condition should arise during surgery which may call for additional or different procedures from those planned, I authorize my doctor to use surgical judgment to provide the appropriate care.
19. I consent to the taking of photographs, video or audio recordings and agree to be interviewed for medical, scientific, or education purposes. Filming or photographing an operation may include my face and may reveal my identity.

## INFORMATION FOR FEMALE PATIENTS

1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of birth control pills.

## CONSENT

I certify that I have had an opportunity to fully read this consent, and that all blanks were filled in before my signing. I also certify that I speak, read and write English. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

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Patient's (or Legal Guardian's) Signature

Date

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Doctor's Signature

Date

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Witness' Signature

Date