

# 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.

Patient's  
Initials

- \_\_\_\_\_ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.
- \_\_\_\_\_ Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me.
- \_\_\_\_\_ I understand and accept that the most likely material risks and complications of otoplasty have been discussed with me and may include but are not limited to:
- allergic reaction to topical preparations
  - asymmetry
  - bleeding
  - change of skin sensation
  - ear trauma
  - infection
  - pain
  - scarring
  - skin contour irregularities
  - unsatisfactory results
- \_\_\_\_\_ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
- \_\_\_\_\_ I understand and accept the risks of blood transfusion(s) that may be necessary.
- \_\_\_\_\_ 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 pre- and postoperative periods could 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.
- \_\_\_\_\_ I have been advised of the probable consequences of declining recommended or alternative therapies.
- \_\_\_\_\_ I have been informed of what to expect postoperatively, 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.
- \_\_\_\_\_ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct \_\_\_\_\_, MD, with associates or assistants of his or her choice, to perform otoplasty on \_\_\_\_\_ at \_\_\_\_\_, on my:

(patient name) (name of facility)

**right ear**

**left ear**

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

\_\_\_\_\_  
Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient or Legal Representative Name

\_\_\_\_\_  
Witness Signature/Date/Time

*Continued*

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

\_\_\_\_\_  
Physician Signature/Date/Time

\_\_\_\_\_  
initial

copy given to patient

\_\_\_\_\_  
initial

original placed in chart

SAMPLE