



Ralph W. Bashioum, MD, FACS
612.449.4900

CONSENT FOR EAR SURGERY

We think it is important that you understand not only the benefits of the surgery you are going to undertake but also all of the risks. For this reason, we have composed this informed consent for you to read and sign. If this information raises any questions, please call or come in to the office so that we can discuss things further.

I, _____, hereby authorize Dr. Bashioum and his staff to perform a surgical operation for protruding ears known as ear surgery or otoplasty.

Dr. Bashioum and the staff at the Bashioum Cosmetic Surgery Center, Ltd. have personally explained ear surgery to me. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I completely understand the nature and consequences of the procedure. The following points, among others, have been specifically made clear.

Alternate treatment methods have been explained. The risks and benefits of each of these have been explained to me.

The procedure is subject to the same postoperative complications as other surgical procedures. Infection, bleeding, abnormal scarring, poor healing, slow healing, skin loss, nerve damage, and/or muscle damage can occur.

Infection although rare can lead to severe deformity of the ear(s) and may require antibiotic treatment, hospitalization, and/or reconstructive surgery.

Sensory nerve injury can lead to numbness or loss of feeling in some part of your ears. Although rare these changes can be permanent.

Cartilage response cannot be predicted before the surgery. Although rare, recurrent protrusion can occur. Further surgery may be necessary to correct these problems.

No guarantee has been given or implied to me as to the result of otoplasty surgery. Asymmetries in the ears are present and surgery may make these differences more pronounced. It is possible that I will want more ear surgery to give a more acceptable result in my ears. Patients choose further surgery about 10% of the time.

The incision will heal with a permanent scar. Placement of the scars has been discussed. The advantages and disadvantages have been explained.

The amount of ear repositioning will be determined at the time of surgery. The staff of the Bashioum Cosmetic Surgery Center will make this decision based on my skin elasticity, sculpted appearance, and safety.

I am not pregnant now nor will I be pregnant at the time of surgery. Pregnancy is not recommended for at least six (6) months after the surgery.

I do not or will not use any illegal drugs prior to my surgery. I understand that these can lead to unexpected responses during the surgery that can result in death. I have also informed Dr. Bashioum and the staff of the Bashioum Cosmetic Surgery Center, Ltd. of all the prescription and nonprescription drugs including herbal or natural treatments that I have been taking.

I recognize that, during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore further authorize and request that Dr. Bashioum and the staff at the Bashioum Cosmetic Surgery Center, Ltd. perform such procedures as are, in his professional judgment, necessary and desirable, including, but not limited to, procedures involving pathology and radiology. The authority granted under this Paragraph shall extend to remedying conditions that are not known to Dr. Bashioum and the staff at the Bashioum Cosmetic Surgery Center, Ltd. at the time the operation is started.

I consent to the administration of local anesthesia, intravenous sedation, and or general anesthesia to be applied by or under the direction and supervision of Dr. Bashioum.

I recognize that when general anesthesia is used and it presents risks over which the above doctors and staff have no control. I agree to discuss the risks of intravenous sedation and general anesthesia with the nurse anesthetist before surgery is performed. I understand that a nurse anesthetist will provide all of my anesthetic care.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made or implied to me as to the results of ear surgery. I understand that it is not possible to control the healing process. I understand that during the year after my surgery there is a 10% chance of a second surgery being required to give me the result that I want.

I consent to be transferred to any available hospital at the discretion of my doctors in the event that such transfer is necessary.

I understand that while receiving care a health care worker may accidentally be exposed to my blood or other bodily fluid. If this rare event occurs, I understand that my blood will be tested for the presence of infectious diseases, including HIV, the AIDS virus. This test is necessary to help protect and counsel the health care worker. I understand the results of the test will be part of my medical record and will not be released except with my prior consent or as required or permitted by law.

I consent to be photographed before, during, and after the treatment. These photographs shall be the property of the Bashioum Cosmetic Surgery Center, Ltd. These photographs may be **published** in scientific journals, **shown** for scientific reasons, and/or used in **patient education** both in and out of the office.

I agree to keep the Bashioum Cosmetic Surgery Center, Ltd. informed of any change of address so that they can notify me of any late findings, and I agree to cooperate with the Bashioum Cosmetic Surgery Center, Ltd. in my care after surgery until completely discharged.

I am not known to be allergic to anything except: _____ . I am not allergic to latex. I have never had high fevers associated with any anesthesia.

I HAVE READ THE ABOVE CONSENT AND RECEIVED A COPY OF IT. ALL OF MY QUESTIONS HAVE BEEN ANSWERED AND I FULLY UNDERSTAND THE CONTENTS OF THE CONSENT AND AUTHORIZE AND REQUEST DR. BASHIOUM AND THE STAFF OF THE BASHIOUM COSMETIC SURGERY CENTER, LTD. TO EAR SURGERY OR OTOPLASTY ON ME.

Patient: _____ Date: _____

Witness: _____ Date: _____

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