Consent for Ear Reduction Surgery (Pinnaplasty)

Bella Vou® Pantiles Clinic

Statement of health professional. I have explained to the patient:

Procedure: Ear Reduction Surgery (Pinnaplasty)

- ☐ Scars behind ears
- ☐ Scars in front of ears
- ☐ Suturing of ear fold
- ☐ Cartilage Excision
- ☐ General Anaesthesia
- ☐ Local Anaethesia
- ☐ Local Anaethesia & Sedation

The intended benefits:

Aesthtic, Psychological, Functional

Significant, unavoidable or frequently occurring risks:

Bleeding, Infection, Scar problems (stretched, thick, abnormal pigmenta on, red, retracted etc.), Skin discolortion, Skin cones, Wound separation, Slough, Necrosis, Pain, Numbness, Bruising, Swelling, Overcorrection, Undercorrection, Asymmetry, Recurrent prominence, Sharp/straight ear folds, Aesthetic imperfections, Functional problems, Contour irregularities, Need for further surgery, Allergic reaction.

N.B. Most complica ons are unlikely. Serious risks or death are rare

Alternatives:

No Surgery, Hair-styling, Ear-molding in young babies, Earfold device

Further detailed and specific information has been provided by email, in the consultation letters and attached leaflets.

Signed: _____ *Hagen Schumacher (Consultant Plastic Surgeon)* **Date:** _____

Statement of interpreter: *I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.*

Signed: _____ **Name:** _____ **Date:** _____

Statement of Patient:

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including afer you have signed this form.

1. I agree to the procedure or course of treatment as described on this form. I confirm my surgeon has explained the risks, complictions and limitations of the procedure at a full consultation. ..... Y / N
2. I agree to a blood transfusion if needed - risks, benefits & alternatives have been explained and discussed. ..... Y / N
3. I understand that tissue removed as part of my treatment may be used for teaching, education, quality assurance or audit inaddition to diagnostic purposes. I consent to the use of residual tissue following diagnosis for research. ..... Y / N
4. I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency prevents this. (This only applies to patients having general or regional anaesthesia). ..... Y / N
5. I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health. ..... Y / N
6. I understand that pre-op and post op care is predominantly the responsibility of the operating surgeon/clinic details of which I have. ..... Y / N
7. I have been offered two consultations and two weeks cooling off period ..... Y / N
8. I agree to the use of photographs for my own medical documentation ..... Y / N
9. I have been told about additional procedures which may become necessary during my treatment. I do not wish to have the following procedures to be carried out without further discussion (e.g. blood transfusion [see above], cardiopulmonary resuscitation etc.) ..... Y / N

Patient Signature: _____ **Date:** _____

A whitness should sign below if the patient is unable to sign but has indicated his or her consent. Young people / children may also like a parent to sign here (see notes).

Whitness Signature: _____ **Name (PRINT):** _____ **Date:** _____

If the patient has signed the form prior to admission. I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Signed: _____ *Hagen Schumacher (Consultant Plastic Surgeon)* **Date:** _____