INFORMED CONSENT FOR

RHINOPLASTY
(NOSE RESHAPING)

(PLEASE REVIEW AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE)

PATIENT NAME _____

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AESTHETIC SURGERY

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MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

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INFORMED CONSENT- RHINOPLASTY, Continued

INSTRUCTIONS

This is an informed consent document that has been prepared to help inform you concerning rhinoplasty surgery, its risks, and alternative treatment.

> It is important that you **read this information carefully and completely**. Please **initial each page**, indicating that you have read the page and **sign the consent for surgery** as proposed by your plastic surgeon(s).

INTRODUCTION

Rhinoplasty is a surgical procedure that can produce changes in the appearance and structure of the tip and dorsum of the nose. Tip rhinoplasty can reduce or increase the size of the nasal tip, change the shape of the tip, narrow the width of the nostrils, or change the angle between the nose and the upper lip. This operation can also help correct birth defects and nasal injuries. Dorsal rhinoplasty can lower or increase the height of bridge of the nose and can narrow or widen the width of bridge as seen on frontal view. There is not a universal type of rhinoplasty surgery that will meet the needs of every patient. Rhinoplasty surgery is customized for each patient, depending on his or her needs. Incisions may be made within the nose or concealed in inconspicuous locations of the nose in the open rhinoplasty procedure. Some techniques of rhinoplasty use cartilage grafts or other man-made materials to enhance the projection of the nasal tip. Internal nasal surgery to improve nasal breathing can be performed at the time of the rhinoplasty. ***The goal of any aesthetic surgery is to get a nice improvement, not perfection.*** In addition to realistic expectations, good health and psychological stability are important qualities for a patient considering rhinoplasty surgery. Rhinoplasty can be performed in conjunction with other surgeries.

ALTERNATIVE TREATMENT

Alternative forms of treatment consist of not undergoing the rhinoplasty surgery. Risks and potential complications are associated with alternative forms of treatment that involve surgery. In some cases, an injection of filler product can be used to reshape the nose instead of a rhinoplasty.

RISKS of RHINOPLASTY SURGERY

Every surgical procedure involves a certain amount of risk and it is important that you understand the risks involved with rhinoplasty surgery. An individual's choice to undergo a surgical procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your plastic surgeon(s) to make sure you understand all possible consequences of rhinoplasty surgery.

Bleeding- It is possible, though unusual, to have problems with bleeding during or after surgery. Should post-operative bleeding occur, it may require emergency treatment to stop the bleeding or drain an accumulation of blood (hematoma). Do not take any aspirin or anti-inflammatory

medications for ten days before surgery, as this contributes to a greater risk of bleeding. Non-prescription "herbs" and dietary supplements can increase the risk of surgical bleeding. Hypertension (high blood pressure) that is not under good medical control may cause bleeding during or after surgery. Accumulations of blood under the skin may delay healing and cause scarring.

Infection- Infection is quite unusual after surgery. Should an infection occur, additional treatment including antibiotics may be necessary. Cartilage grafts, if used, may require removal should an infection occur.

INFORMED CONSENT- RHINOPLASTY, Continued

Scarring- Although good wound healing after a surgical procedure is expected, abnormal scars may occur both within the skin and the deeper tissues. Scars may be unattractive and of different color than the surrounding skin. There is the possibility of visible marks from sutures. Additional treatments including surgery may be needed to treat scarring.

Damage to deeper structures- Deeper structures such as nerves, blood vessels and cartilage may be damaged during surgery. The potential for this to occur varies with the type of rhinoplasty procedure performed. Injury to deeper structures may be temporary or permanent.

Numbness- There is the potential for permanent numbness within the nasal skin after rhinoplasty. The occurrence of this is not predictable. Diminished (or loss) of skin sensation in the nasal area may not totally resolve after rhinoplasty. There is also a potential for alteration of the sense of smell, either increased or decreased.

Unsatisfactory result- There is the possibility of an unsatisfactory result from rhinoplasty surgery. The surgery may result in unacceptable visible or tactile deformities, loss of function, or structural malposition after rhinoplasty surgery. You may be disappointed that the results of rhinoplasty surgery do not meet your expectations. Additional surgery may be necessary should the result of rhinoplasty be unsatisfactory.

Cartilage grafts- Cartilage grafts may be needed if the goal of surgery is to change the projection of the nasal tip. These grafts can be obtained from donor locations within the nose (nasal septum) or from other parts of the body. Complications including nasal septal perforation may occur from the procurement of cartilage graft material. More than one location may be needed in order to obtain sufficient amounts of cartilage.

Asymmetry- The human face is normally asymmetrical. Variation from one side to the other may result from a rhinoplasty procedure.

Chronic pain- Very infrequently, chronic pain may occur very infrequently after rhinoplasty.

Skin disorders/skin cancer- Skin disorders and skin cancer may occur independently of rhinoplasty surgery.

Allergic reactions- In rare cases, local allergies to tape, suture material, or topical preparations have been reported. Systemic reactions which are more serious may result from drugs used during surgery and prescription medicines. Allergic reactions may require additional treatment.

Delayed healing- Wound disruption or delayed wound healing is possible. Some areas of the nose may heal abnormally or slowly. Areas of skin may die, requiring frequent dressing changes or further surgery to remove the non-healed tissue.

Long term effects- Subsequent alterations in nasal appearance may occur as the result of aging, sun exposure, or other circumstances not related to rhinoplasty surgery. Future surgery or other treatments may be necessary to maintain the results of a rhinoplasty operation.

Nasal septal perforation- Rarely, a hole in the nasal septum will develop. Additional surgical treatment may be necessary to repair the nasal septum. In some cases, it may be impossible to correct this complication.

Nasal airway alterations- Changes may occur after a rhinoplasty operation that may interfere with normal passage of air through the nose.

Rhinits- Symptoms of rhinitis, including persistent nasal drainage, may continue or develop after surgery. These symptoms are generally unrelated to the surgery and may involve further treatment after surgery.

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical operations or any complications that might occur from cosmetic surgery. If the procedure corrects a breathing problem or marked deformity after a nasal fracture, or a birth defect, a portion may be covered. Please carefully review your health insurance subscriber-information pamphlet.

ADDITIONAL SURGERY NECESSARY

There are many variable conditions in addition to risk and potential surgical complications that may influence the long term result from rhinoplasty surgery. Even though risks and complications occur infrequently. The risks cited are particularly associated with rhinoplasty surgery. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied as to the results that may be obtained. Infrequently, it is necessary to perform additional surgery to improve your results. *The standard revision rate of rhinoplasty is between 10-20%.*

FINANCIAL RESPONSIBILITIES

The cost of surgery involves several charges for the services provided. The total includes fees charged by your doctor, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day surgery charges involved with revisional surgery would also be your responsibility.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your plastic surgeon(s) may provide you with additional or different information, which is based on all the facts in your particular case and the state of medical knowledge. Informed-consent documents are not intended to define or serve as the standard of medical care. Standards

of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent on the next page.

CONSENT FOR SURGERY / PROCEDURE or TREATMENT

1. I hereby authorize Dr. Karol Gutowski and/or Dr. Julia Kerolus and such assistants as may be selected to perform the following procedure or treatment:

Rhinoplasty

I have received the following information sheet:

INFORMED CONSENT for RHINOPLASTY SURGERY

2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician(s) and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician(s) at the time the procedure is begun.

3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involves risk and the possibility of complications, injury, and sometimes death.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

5. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.

7. I consent to the disposal of any tissue, medical devices or body parts which may be removed.

8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.

9. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
   b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
   c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9).

I AM SATISFIED WITH THE EXPLANATION.

_____

Patient or Person Authorized to Sign for Patient

Date_____ _____Witness

AUTHORIZATION & CONSENT FOR RELEASE OF MEDICAL IMAGES

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Dr. Gutowski and/or Dr. Kerolus or their representatives.

INTRODUCTION

Medical images (photographs, slides, videos, interviews or any other images of you, or components of your medical record) may be taken before, during, or after a surgical procedure or treatment. These images may be needed to document your medical condition, used as supporting material for authorizing medical coverage and payments, and treatment planning. Consent is required to take, use and release such images. Since Drs. Gutowski and Kerolus are also educators of other physicians, researchers, and medical writers, your images may be used for other purposes as described below.

1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOTAPES

I hereby authorize Dr. Gutowski or Dr. Kerolus and/or their associates to take any images before, during and after my treatments or surgeries.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Dr. Gutowski and/or Dr. Kerolus and their associates to use any of these images for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks including the internet, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in supporting documentation for insurance or third-party payer purposes, medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences, and print marketing material (magazine, newspaper, etc) or electronic media (television, internet, etc).

3. CONSENT FOR RELEASE TO PROFESSIONAL ORGANIZATIONS

I further authorize Dr. Gutowski and/or Dr. Kerolus and their associated to release such images to the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), the American Board of Plastic Surgery (ABPS), the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), and the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS). I provide this authorization as a voluntary contribution in the interests of public education. The images may be used for publication in print, visual or electronic media, specifically including, but not limited to, medical journals (such as *Plastic and Reconstructive Surgery, Annals of Plastic Surgery, Aesthetic Plastic Surgery)*, textbooks, lay publications, patient education or during lectures for the purpose of informing the medical profession or the general public about plastic surgery methods, medical education or examination material by ASPS, ASAPS, ABPS, AAFPRS and ABFPRS. I understand that such images shall become the property of ASPS, ASAPS, ABPS, AAFPRS and ABFPRS and may be retained or released by these organizations for the limited purpose mentioned above. I also grant permission for the use of any of my medical records including illustrations, photographs, video or other imaging records created in my case, for use in examination, certifying and/or re-certifying purposes by ABPS and ABFPRS.

I understand that I will <u>not</u> be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge Dr. Gutowski and/or Dr. Kerolus and all parties acting on their authority from all rights that I may have in these images, and from any claims that I have related their use in the above mentioned manner.

I also release Dr. Gutowski and/or Dr. Kerolus and any employees or agents from all liability, including any claims of libel or invasion or privacy, directly or indirectly connected with, arising out of or resulting from the taking and authorized use of these images or recorded interviews.

I understand that I have the right to request cessation of recording or filming at any time.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient Name _____

Patient Signature _____ Date _____

Witness or Guardian/Parent_____ Date _____