INFORMED CONSENT FOR

EAR LOBE SURGERY

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

PATIENT NAME _____

KAROL A GUTOWSKI, MD, FACS

AESTHETIC SURGERY
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

JULIA L KEROLUS, MD

FACIAL PLASTIC SURGERY
CERTIFIED BY THE AMERICAN BOARD OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
MEMBER AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT INITIALS _____

INSTRUCTIONS

This is an informed-consent document that has been prepared to help your plastic surgeon inform you about the risks and alternative treatments of ear lobe surgery.

> 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.

INTRODUCTION

Ear lobe is a surgical process to reshape the ear lobe. A variety of different techniques and approaches may be used to reshape congenital prominence in the ear lobes or to restore damaged ear lobes. Each individual seeking ear lobe surgery is unique both in terms of the appearance of their ears and expectations for results following ear lobe surgery. It is important that you fully discuss your expectations with your plastic surgeon prior to surgery.

ALTERNATIVE TREATMENTS

Alternative treatments are limited to ear reshaping with molds and splints but must be done shortly after birth.

RISKS OF BODY EAR SURGERY

Every surgical procedure involves a certain amount of risk and it is important that you understand the risks involved with ear 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 to make sure you understand the consequences of surgery.

Bleeding- It is possible, though unusual, to experience a bleeding episode during or after surgery. Should post-operative bleeding occur, it may require emergency treatment to drain accumulated blood or blood transfusion. Do not take any aspirin or anti-inflammatory medications for ten days before surgery, as this may increase the risk of bleeding. Non-prescription "herbs" and dietary supplements can increase the risk of surgical bleeding.

Infection - Infection is unusual after this type of surgery. Should an infection occur, treatment including antibiotics or additional surgery may be necessary.

Change in skin sensation- Diminished skin sensation may occure after surgery.

Skin contour irregularities and discoloration- Contour irregularities and depressions may occur after surgery. Visible and palpable wrinkling of skin can occur. Rarely does the skin in the treated area change color.

Skin scarring - Excessive scarring is uncommon. In rare cases, abnormal scars may result. Scars may be unattractive and of different color than surrounding skin. Additional treatments including surgery may be necessary to treat abnormal scarring.

Surgical anesthesia- Both local and general anesthesia involves risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia or sedation.

Asymmetry- Symmetrical body appearance may not result after surgery.

Tissue distortion – Treated areas may stretch or become distorted over time. This may be difficult to correct and may require further surgery.

Delayed healing- Wound disruption or delayed wound healing is possible. Some areas of the body may not heal normally and may take a long time to heal. Some areas of skin may die. This may require frequent dressing changes or further surgery to remove the non-healed tissue.

Smokers have a greater risk of skin loss and wound healing complications.

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

Long term effects- Subsequent alterations in body contour may occur as the result of aging, weight loss or gain, pregnancy, or other circumstances not related to body contouring surgery.

Pain- Chronic pain may occur very infrequently from nerves becoming trapped in scar tissue after ear surgery.

Prolonged Swelling - In some cases, the tissue may swell more than expected after surgery and may stay swollen. This may not improve and may require further treatment.

Other- You may be disappointed with the results of surgery. Infrequently, it is necessary to perform additional surgery to improve your results.

ADDITIONAL SURGERY NECESSARY

Should complications occur, additional surgery or other treatments may be necessary. Even though risks and complications occur infrequently, the risks cited are particularly associated with body contouring surgery. Other complications and risks can occur but are even more uncommon. 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, on the results that may be obtained.

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical operations such as ear reshaping surgery or any complications that might occur from surgery. Please carefully review your health insurance subscriber-information pamphlet.

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 revisionary 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 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 Keorlus and such assistants as may be selected to perform the following procedure or treatment:

   Ear Lobe Surgery

   I have received the following information sheet:

   INFORMED-CONSENT FOR EAR LOBE 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 _____