NASAL SURGERY (RHINOPLASTY) CONSENT

Patient Name **Date**

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

I have been informed that I have the following condition(s):______________________________
____

The procedure(s) to treat my condition(s) has/have been described as: ___________________
____

SURGERY OF THE NOSE

I hereby acknowledge that the following has been explained to me and I have had the opportunity to ask questions.

____1. Rhinoplasty is the reshaping of the nose to improve its appearance and/or attempt to improve breathing function. Rhinoplasty may be done in conjunction with an operation to relieve nasal obstruction due to internal nasal deformity.

____2. I understand that although nasal surgery is typically performed to reduce the overall size of the nose, reshape the tip of the nose, remove a nasal hump or improve a poor angle between the nose and the upper lip, satisfactory changes in appearance cannot be guaranteed. Aesthetic considerations are individual and I acknowledge that my doctor has not made any warranties or assurances that my appearance will be improved.

____3. I have been completely honest with my surgeon regarding my motivation for undergoing nasal surgery, realizing that a new appearance does not guarantee an improved life.

____4. If I use tobacco, I understand that I must cease the use of all tobacco products for 2-3 weeks prior to and after surgery. Failure to do so may have serious negative effects on the success of my surgery.

SUGICAL CONSIDERATIONS

____5. Nasal surgery may be performed under local anesthesia, usually combined with pre-operative sedation or intravenous sedation to relieve anxiety, or with general anesthesia. The procedure may be performed in the office, an out-patient surgery facility or a hospital, depending upon my doctor’s surgical judgment.

____6. Nasal surgery usually involves incisions from inside the nose, but may require skin incisions. Cartilage and bone which support and shape the nose will be surgically altered to change the external appearance of the nose. The result may also reduce airway restriction.

____7. Cartilage may be removed from the tip of the nose to change contour. The nasal septum (or center strut of the nose) may be trimmed to correct any deviation which may be impeding the airway. If a large hump on the nose is removed, the base of the nose may appear disproportionately wide. I have been advised that small wedges of

skin may be removed from the nostrils to create a more balanced appearance. Sometimes cartilage grafts may be used. They have the potential to resorb over time.

POST-OPERATIVE CONSIDERATIONS

____8. Following surgery, a rigid bandage is applied to the nose to maintain the newly created shape. Frequently nasal packs are inserted to protect the nasal septum and to help maintain shape. The splint may be worn for two or more weeks and the packing may remain for several days.

____9. Post-operative swelling and bruising should be expected for approximately two weeks. To reduce this condition, your head should be elevated and cold compresses should be applied around the eyes. Residual bruising may be noticeable for several weeks and subtle swelling of the nose may be present for several months. In the event there is significant narrowing of the nostrils, the external incision in the skin may leave a slight scar in the crease of each nostril.

____10. I understand that results may not be dramatic and that my final appearance may not be stabilized for several months after surgery. There is no guarantee that nasal surgery will improve my appearance or improve the ability to breath better through my nose.

RISK AND COMPLICATIONS

____11. Infection which may require antibiotics and, in some cases, hospitalization.

____12. Extended swelling and bruising.

____13. Excessive bleeding during or after surgery which may require additional blood by way of transfusion. I acknowledge I have been advised of the opportunity for donation of my own (or family members') blood before surgery so that blood may be given back to me if necessary.

____14. Nausea and vomiting, particularly if there is bleeding and blood is swallowed.

____15. "Nose breathers" may experience airway restriction during the initial post-operative period, causing a feeling of "air hunger." There will be a feeling of pressure from the packing used post-operatively.

____16. I understand that I must avoid excessive physical activities that raise the blood pressure such as jogging, swimming, weight lifting and bending for the first several weeks after surgery.

____17. There is a potential for relapse. Additional surgeries may be required for revision or adjustment to further enhance airway or appearance.

____18. Some pain is to be expected and will be controlled by prescription of appropriate medications.

____19. Sometimes the sense of smell is diminished, rarely permanently.

____20. Post-surgical asymmetry (disproportion between left and right sides of the nose) and drooping of the nasal tip can develop. If problematic, may require additional surgical correction.

____21. **ANESTHESIA**

The anesthetic I have chosen for my surgery is:

☐ Local Anesthesia

☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia

☐ Local with Oral Premedication

☐ Local with Intravenous Sedation

☐ General Anesthesia

____22. **ANESTHETIC RISKS** Include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage and/or death.

____23. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**

A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.

B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**

D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a sip of water.**

NO GUARANTEE OF TREATMENT RESULTS

____24. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there is a risk of failure or relapse, my condition may worsen, and selective re-treatment may be required in spite of the care provided.

____25. I have had an opportunity to discuss my past medical and social history, including drug and alcohol use, with my doctor and I have fully informed him of all aspects of my health history, recognizing that withholding information may jeopardize the planned goals of surgery.

____26. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that any lack of cooperation can result in a less-than-optimal result, or may be life-threatening.

____27. If any unforeseen condition should arise during which may call for additional or different procedures from those planned, I authorize my doctor to use surgical judgment to provide the appropriate care.

____28. I consent to the taking of photographs, video or audio recordings and agree to be interviewed for medical, scientific, or education purposes. Filming or photographing an operation may include my face and may reveal my identity.

INFORMATION FOR FEMALE PATIENTS

____29. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conceptions and pregnancy. I agree to consult with my physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return to the use of birth control pills.

CONSENT

I certify that I have had an opportunity to fully read this consent, and that all blanks were filled in before my signing. I also certify that I read, speak and write English. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

____

Patient's (or Legal Guardian's) Signature **Date**

____

Doctor's Signature **Date**

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Witness' Signature **Date**