BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Rhinoplasty

This information is given to you so that you can make an informed decision about having **rhinoplasty.**

Reason and Purpose of the Procedure

Rhinoplasty is a surgery done to change the shape or function of the nose. It can make the size and shape of the tip of the nose larger or smaller. The width of nostrils can be narrowed. The angle between the nose and upper lip can be changed. Birth defects can be corrected. Nasal injuries can be repaired to help relieve breathing problems. This surgery is customized for each person. Incisions may be made within the nose or hidden in external locations.

Benefits of this Surgery or Procedure

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the possible benefits are worth the risk.

- Change in shape of the nose.

Risks of Surgery or Procedure

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General Risks of Surgery or Procedure

- **Small areas of the lungs may collapse.** This would increase the risk of infection. This may need antibiotics and breathing treatments.
- **Clots may form in the legs, with pain and swelling.** These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- **A strain on the heart or a stroke may occur.**
- **Bleeding may occur.** If bleeding is excessive, you may need a transfusion.
- **Reaction to the anesthetic may occur**. The most common reactions are nausea and vomiting. In rare cases, death may occur

Risks of this Surgery or Procedure

- **Infection**. May require antibiotics or additional surgery.
- **Change in skin sensation.** This may not change.
- **Skin scarring.** More treatment including surgery may be needed.
- **Chronic nose pain**.
- **Slow healing**. This may require frequent dressing changes or more surgery.
- **Allergic reactions to medication given, tape, suture or topical preparation-**additional treatment would be required.
- **Damage to other structures such as nerves, muscle, or blood vessels.** This may be temporary or permanent.

Risks Associated with Smoking

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications, clot formation, skin loss, or wound healing delays.

Risks Associated with Obesity

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You

_____

_____

_____

_____

Alternative Treatments

Other choices

- Do nothing. You can decide not to have the procedure.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

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By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Rhinoplasty.**
- I understand that other doctors, including medical residents or other staff may help with surgery or procedure. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. If so, please obtain consent for blood/products.

Patient Signature_____Date:_____Time:_____
Relationship: □Patient □Closest relative (relationship)_____ □Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter:_____Date_____Time_____
Interpreter (if applicable)

For Provider Use ONLY:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature:_____ Date:_____ Time:_____

Teach Back
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:
____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____

OR
____ Patient elects not to proceed: _____ Date:_____ Time:_____
(patient signature)
Validated/Witness:_____ Date:_____ Time:_____