
Dr.Krishna S Chaudhari
M.S.DORL.MB FICCS(Cosmetic)
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10 to 1 pm;6 to 8 pm.Sunday closed.

## OTOPLASTY Consent Form

To the patient: You have the right to be informed about your treatment so that you may make a decision to undergo the procedure, knowing the risks and hazards involved.

I _____ have received a consultation with a Surgeon and I consent to the treatment of an Otoplasty to be carried out upon myself / my child for the improvement of Prominent Ear/s .

I understand that I am required to return the next day for a wound check and after 7 days for the removal of my sutures with the Practice Nurse and have two follow-up consultations at 6 and 12 weeks. I also understand that I am required to have photographs taken before, during and after treatment for my medical records.

I have been informed about the treatment, procedure, indications, expected results and possible side effects. I understand that I may experience Scarring, Asymmetry, Unfolding of Ears back to their pre-operative state, Bleeding, Nerve Damage, Infection, Numbness, Bruising, Swelling and Puckering / dimpling of the skin (usually temporary), however these symptoms are rare and in most cases will resolve.

I understand the importance of my post-operative care and I have been give information regarding this.

Although the results are usually dramatic I have been informed that the practice of Medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case.

I agree to the Doctor administering a local anaesthetic nerve block prior to treatment if necessary for pain relief.

I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and no guarantee can be made as to the exact results of this procedure. I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur.

I accept responsibility for any complications that may occur and thereby absolve Dr.Chaudhari & associates and any associated person of any blame resulting there from.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

I understand that the terms of payment require full settlement on or before the day of my treatment.

Patient Signature: _____Date:

Surgeon/Registered Nurse Signature: _____ Date:

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