



*Joe Niantu, III, D.M.D.*  
 COSMETIC FACIAL SURGERY  
 804-934-3223 (FACE)  
 11319 Polo Place Midlothian, VA 23113  
 www.lovethatface.com

**CONSENT FOR EAR SURGERY (OTOPLASTY)**

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| Patient's Name | Chart # | Date |
|----------------|---------|------|
|----------------|---------|------|

I have been informed that I have the following condition(s): \_\_\_\_\_  
 \_\_\_\_\_

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

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

**Ear Surgery**

- \_\_\_\_ 1. Otoplasty is a form of ear surgery performed to change the appearance of disproportionately large or prominent ears by positioning them closer to the head.
- \_\_\_\_ 2. Ear surgery may be performed under local anesthesia (numbing of the area), often in conjunction with pre-operative sedation, intravenous sedation or general anesthesia to help relieve anxiety.
- \_\_\_\_ 3. I have been advised and I understand that there is no guarantee that ear surgery will improve my appearance or correct any pre-existing condition(s).
- \_\_\_\_ 4. I have been completely honest with my doctor regarding my motivation for undergoing ear surgery and realize that a new appearance to my ears does not guarantee an improved life.
- \_\_\_\_ 5. If I use tobacco, I understand that I must cease all such use at least two weeks prior to surgery. Failure to do so may have serious effects on the success of my surgery.

**Surgical Considerations**

- \_\_\_\_ 1. Incisions will be made in the back of the ear and the skin opened to expose the ear cartilage, which shapes the ear. The cartilage will then be surgically repositioned or reshaped in an attempt to improve appearance and function. The skin incisions will be closed with stitches. I have been told and understand that a residual scar behind the ear can be expected. In most cases, especially in children, the scar fades with time. However, the scar line may be permanent and, due to individual healing differences, may require an additional procedure (scar revision) to attempt to minimize its visibility.
- \_\_\_\_ 2. Additional procedures may be performed to help better the outcome of surgery at no charge. A materials fee will be incurred at cost of patient.

**Post-Operative Considerations**

- \_\_\_\_ 1. After surgery the ear will be covered with a bulky pressure dressing. Some surgical discomfort can be expected and is usually controlled with medication. In rare cases, discomfort may be prolonged for several weeks. If surgery is done in a hospital, a stay of a few days may be required.
- \_\_\_\_ 2. In a few days the bulky dressing will usually be removed, after which a light head dressing will be required for several weeks. The area may exhibit some swelling and bruising.

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- \_\_\_3. In some cases, as a result of the new ear position, the fold in the ear may appear more prominent.
- \_\_\_4. Patients, particularly children, should refrain from excessive or strenuous physical activity such as lifting, heavy labor, swimming or sports activity for several weeks.

**Risks and Complications**

- \_\_\_1. Bruising, swelling and discomfort for an indeterminate time.
- \_\_\_2. Residual or permanent scarring behind the ear.
- \_\_\_3. Infection which may require antibiotics. In cases of severe infection, hospitalization and additional treatment may be required.
- \_\_\_4. Bleeding is usually slight, but may occasionally be excessive, in which case additional treatment may be required. Very rarely, blood transfusions may be required, and I have been advised of my rights concerning donation of my own blood before surgery so it may be transfused back to me if necessary.
- \_\_\_5. Asymmetry of the ears - one side may appear different from the other.
- \_\_\_6. The operated ears may tend to return to their original position (relapse) requiring additional corrective surgery. This is a particular risk when careful attention is not paid to prescribed post-operative instructions.
- \_\_\_7. In rare cases, a blood clot may occur at the site of surgery requiring drainage or a follow-up procedure.
- \_\_\_8. Failure to follow post-operative instructions may increase the risk of any of the foregoing.
- \_\_\_9. Some numbness of the skin of the ear may result. Usually it is temporary, but may rarely be permanent.

**No Guarantee of Treatment Results**

- \_\_\_1. 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 retreatment may be required in spite of the care provided.
- \_\_\_2. 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/her of all aspects of my health history, recognizing that withholding information may jeopardize the planned goals of surgery.
- \_\_\_3. 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.
- \_\_\_4. If any unforeseen condition should arise during surgery that may call for additional or different procedures from those planned, I authorize my doctor to use surgical judgment to provide the appropriate care.
- \_\_\_5. Revision surgery, although rare, is a possibility with any cosmetic procedure. Post operative touch ups are usually minor and most often performed with local anesthesia. A surgical fee will be charged commensurate with the extent of the revision.

\_\_\_\_6. I realize the human face and head are not symmetric and that one side of my anatomy may be larger or smaller than the other side and due to this absolute symmetry may not be realistic or possible. In other words, I may have to settle for slight imperfection or asymmetry.

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**Female Patients**

\_\_\_\_1. I have advised Dr. Niamtu as to whether or not I am currently utilizing birth control pills. I have been advised and informed that certain antibiotics and some pain medications may neutralize the therapeutic effect of birth control pills, allowing for conception and resulting in pregnancy. I agree to consult with my family physician to initiate additional forms of mechanical birth control during the period of my treatment with Dr. Niamtu until I am advised that I can return to the exclusive use of birth control pills by my physician.

**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 indicated my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

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Patient's (or Legal Guardian's) Signature

Date

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Witness' Signature

Date

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Doctor's Signature

Date