PROMINENT EAR SURGERY
PATIENT INFORMATION AND CONSENT FORM

Patient's Name, Surname:

TC Identification number:

Father name:

Mother name:

Date of birth:

Dear Patient, Dear Parent/Guardian,
This written form will inform you about the treatment/surgery and related complications (surgery).
problems, side effects that may occur during or after
prepared to explain. Please read the form carefully and answer the questions.
This form contains the written form of the information that is verbally explained to you and HOSPITAL TO USE IF NEEDED
will be stored in the archive.

As a result of the examination, it was decided that you/your patient need surgery. your physician
Before the operation, you will give the information written in this document to you, and at the end of this, you will make your decision with your FREE WILL to perform the operation.
EACH PAGE of this form is LEGALLY signed by you and a relative.
MUST.

1. Information about the disease:

Many different deformities can be seen in the ear, either congenital or acquired. The most common shape problem that disrupts the aesthetic appearance is the prominent ear. Prominent ear is the name given to the deformity in which the ear is excessively open from the head to the side, and although some other factors also contribute, the most important reason is the underdevelopment of the ear fold, which is called the 'anthelix' in the medical language.

The aim of the surgery is not to make the ear adhere to the skull base, but to be unobtrusive, possible.
The goal is to get a natural looking ear that is as symmetrical as possible.

Diagnosis _____

Treatment/procedure to be applied _____

Side/grade if applicable ☐ Right sided ☐ Left sided ☐ Both sided Grade _____

Should you not intend to be informed about the purpose, duration, advantages, success ratio, potential risks and complications and alternative options of the treatment to be applied and as well as about the subsequent potential risks in case you do not accept the treatment, please declare so below with your hand writing.

_____

I hereby declare that;

My attending physician informed me about my disease, the treatment option to be applied, its duration, advantages, success ratio, the fact that it does not necessarily guarantee the recovery of current status, period of healing, potential risks and complications, alternative techniques, the potential situations I will experience on the condition that I reject the treatment and compulsory performance of an additional operation/intervention/procedure if deemed necessary and s/he answered all my questions regarding these matters.

Above mentioned procedure has been disclosed to be performed on myself/patient I legally represent by the physicians, nurses as well as other healthcare professionals under the authority, surveillance and control of my attending physician.

I have been informed that if required, anesthesia will be performed by an anesthetist, sedation will be performed by an anesthetist or another physician competent in sedation and local anesthesia will be performed by my attending physician.

While being entitled to make decision and think straightly, I accept the medical procedure to be performed, and consent that my attending physician and his/her team will carry out any medical treatment option/surgical technique/intervention they deem to be necessary.

I authorize the hospital to examine, inspect, dispose of or keep the tissues or organs removed during the procedure for which I have consented above.

I allow my medical reports to be used for scientific researches provided that my identifying information is kept hidden.

Patient's Full Name: Date of Birth:	Signature:	Date:	Time:
Legal Representative's Full Name: Degree of Relationship: Reason why the consent is delivered by legal representative of the patient: ☐ Patient is not conscious ☐ Patient is under 18 ☐ Patient is not entitled to make decision ☐ Emergency	Signature:	Date:	Time:
Witness' Full Name:	Signature:	Date:	Time:
Informing Physician's Full Name:	Signature:	Date:	Time:
Interpreter's (If required) Full Name:	Signature:	Date:	Time:

Informed consent is delivered by the patient himself/herself if s/he is older than 18 years old, by the patient himself/herself together with his/her legal representative if the patient is aged between 15 and 18 and by the representative of the patient if the patient is under 15 years old and/or is unconscious and/or is not entitled to make decision and in case of emergency.