INFORMED CONSENT FORM

Tip Rhinoplasty

This draft supports, but does not replace, an in-person discussion with the surgeon. Do not sign until the individualized procedure plan and risks have been completed.

PATIENT AND PROCEDURE DETAILS

Full name: _____

Date of birth: _____

Patient / file number: _____

Counseling date: _____

Facility / place of surgery: _____

Proposed procedure, side and area: _____

Procedure overview

Tip rhinoplasty is an operation intended to change nasal-tip shape, projection, rotation or symmetry. An open or closed approach may be used. Cartilage grafts may be obtained from the septum, ear or another donor site when indicated. Your surgeon must separately describe the planned surgical extent, any septal or airway procedures, and graft sources.

Purpose and potential benefits

The aim is to improve nasal-tip appearance in proportion to the face. Healing depends on individual tissues; perfect symmetry, a particular photographic result and a guaranteed outcome are not possible.

Alternatives

Decline surgery and retain the present appearance; discuss the limited role of non-surgical options when relevant; assess whether comprehensive rhinoplasty or functional nasal surgery is more appropriate.

Procedure-specific risks

Possible complications include tip asymmetry, contour irregularity, firmness, collapse or overprojection; prolonged swelling; altered sensation of the tip or upper lip; visible scars; graft displacement, visibility, absorption or infection; pain/scarring at a donor site; nasal obstruction or altered airflow; septal perforation; and the need for revision surgery.

Postoperative care

Follow individual splint, taping and wound-care instructions. Avoid pressure or trauma to the nose; obtain personalized advice on glasses, exercise, flights, work, smoking and medications. Final refinement may take months.

Questions for your surgeon

Will a cartilage graft be needed, and from where? Could breathing change? What factors increase the chance of revision?

General surgical and anesthesia risks

Any operation can involve bleeding, hematoma, infection, delayed healing, wound separation, scarring, pain, numbness, swelling, allergy or medication reactions, venous blood clots (DVT or pulmonary embolism), anesthesia-related complications and, rarely, life-threatening events. Individual risks vary with health status and procedure.

Personal factors affecting risk

Tell the surgeon about smoking/nicotine use, diabetes, high blood pressure, cardiac or lung conditions, previous operations, bleeding or clotting disorders, poor wound healing, possible pregnancy, prescribed medicines, hormones, supplements and allergies. Do not stop prescribed medications without medical advice.

Expectations, additional treatment and costs

Cosmetic outcomes are personal and subjective. Asymmetry, persistent scars, dissatisfaction or unexpected healing may require additional care or revision. Timing, feasibility, likely benefit and potential additional costs of revision must be discussed separately.

Recovery and warning signs

Attend follow-up appointments. Seek prompt care for fever, worsening redness, pus, increasing bleeding, uncontrolled pain, sudden shortness of breath, chest pain or new swelling of one leg. Procedure-specific emergency warning signs are described above.

Alternatives and right to decline

You may decline the proposed operation, obtain a second opinion and withdraw consent before the intervention begins. Declining elective cosmetic surgery usually means retaining the current appearance; functional concerns should be assessed separately.

Photographs and privacy

Clinical photographs and medical records needed for care must be handled under applicable health-data confidentiality rules. Educational, social media, advertising or other public use is NOT authorized by this surgical consent and requires separate explicit permission.

INDIVIDUALIZED PLAN AND RISK NOTES (TO BE COMPLETED BY SURGEON)

Incisions, technique, side and additional procedures: _____

_____

Relevant conditions / risks / allergies / medications: _____

_____

Anesthesia and estimated duration: _____

_____

PATIENT COUNSELING AND DECISION RECORD

The purpose, technique, reasonable alternatives, consequences of declining surgery, significant risks, expected recovery and emergency warning signs were explained to me in a language I understand. I could ask questions and seek another opinion. I understand that outcomes are not guaranteed and additional care or revision may be needed. I know I can withdraw my consent before the procedure begins.

[ ] I consent to the procedure individualized and explained above.

[ ] I decline the proposed procedure / defer my decision.

Patient printed name and signature: _____

Date / Time: _____

Counseling surgeon name and signature: _____

Date / Time: _____

Legal representative, relationship and signature (if applicable):

_____

Date / Time: _____

Interpreter name, language and signature (if applicable): _____

Date / Time: _____

DRAFT • Requires surgeon and legal review • Not approved for clinical use