J. GOVRIN M.D.
Plastic Surgeon - Specialist
O.J. Govrin Refua LTD

ד"ר ג'קי גוברין
מנתח פלסטי - מומחה
א.ג. גוברין רפואה בע"מ

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Haifa 13 Sherit Hapleta st.
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מרפאות
חיפה - בית הרופאים, שד' בן גוריון 4
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נהריה - רח' סוקולוב 21

Consent form: cosmetic surgery of the auricle – otoplasty

The operation is intended as a cosmetic correction of the position of the ear auricles and their shape.
The operation is performed under local anesthesia and additional sedation or under general anesthesia
Name of the patient: ________________________ID no.: __________________
I hereby testify and confirm that I have received a comprehensive oral explanation by Dr.____________ on: esthetic right auricle/ left auricle/ both auricles surgery/ the technique that will be adopted:
(hereinafter: "the main operation").
I hereby testify and confirm that I have received explanations on the anticipated outcome and the limited correction capability of the operation, including the possibility of asymmetry of the ears and/or a return of the ear to its previous condition.
And that I have received explanations on the side-effects of the main operation including pain, subcutaneous bleeding, nausea and vomiting, discomfort and changes of sensation of the skin of the auricle. I have received explanations that the surgical incisions are done on the anterior or posterior part of the skin of the auricle and that sometimes it is necessary to remove part of the cartilage. I have received explanations that scars will remain at the incisions sites that may improve with time; however, upon close scrutiny, it will be possible to notice them. In cases where cartilage is removed from the auricle, there is the possibility of the formation of a skin fold in front of the auricle. I have received explanations that the shape of the scars depends on the type of my skin and its healing properties, and in some cases, colloid scars may develop (red, prominent and itching).
Similarly, I have received explanations on the potential risks and complications including: infection up to a loss of skin and/or cartilage, a gap of the incisions margins, exposure of sutures, and absence of sensation in the skin of the auricle, chronic pain at the surgical site, changes of color and deformations of the auricle. In rare cases, bleeding may appear that necessitates an emergency operation.
I hereby give my consent to the performing of the main operation.
I have received explanations that the operation is performed under local anesthesia and deep sedation. I will receive an explanation on general anesthesia by the anesthesiologist.
Similarly I hereby testify and confirm that I received explanations and I understand that there is a possibility in the course of the main operation that it will be necessary to extend its scope, to change it or to recur to other or additional procedures for the saving of life or prevention of bodily harm, including surgical procedures that cannot be foreseen now with certainty or in full; however, their significance was explained to me. Thus, I consent also to the aforesaid extension, change or performing of other or additional procedures, including surgical procedures that in the surgeon's opinion will be vital or necessary during the main operation.

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I consent to the taking of pictures before and after treatment for purposes of science, recording and monitoring.
I have received explanations that medicine and plastic surgery in particular, are not an exact science, and that it is not possible to prevent entirely complications and adverse outcomes. The surgeon undertakes to treat assiduously any complication or adverse outcome; however, it was made clear to me that no pecuniary indemnification of any kind will be awarded, for a post-operative complication or adverse outcome. Similarly, no coverage will be awarded for any pecuniary or other damage incurred in connection with the treatment such as a loss of working days, purchasing of drugs, special trips, hospitalization, and/or any direct or indirect damage incurred in direct or indirect connection with the outcome of the treatment that I will receive.
If a decision is taken after the recovery period, that usually takes a year, that corrective surgery is necessary, it will be performed with the consent of the 2 parties and at cost price of the operating room only.
I undertake to continue the periodic follow-up by the surgeon or the attending physician as they determine, and notify on time of any unforeseen change in the healing process.
I testify that I have had time to peruse it and to receive another opinion of my choice.
Signature of the patient/guardian on the day of receipt of the form for the first time:
_________________ Date: ___________Time: ______________
Signature of the patient/guardian for the second time: __________________
Date: ___________________Time: _________________
I testify that I have explained to the patient/ guardian all the aforesaid in the necessary detail and that the signature was put after I was satisfied that my explanations were fully understood.
Stamp and signature of the physician: ___________
Date: ______________Time: ____________