Consent to Face Contouring Surgery (Template)

A Form in Duplicate

Patient's Name:________________ Patient's Date of Birth:________________________

Medical Record No. :_______________ Name of Responsible Physician:_____________________________________

I. Surgery to be implemented (please add a brief explanation for any complicated medical term)

1. Recommended Surgery (Site):
2. Recommended Reason for the Surgery:

(please note the specific side for the part with difference of left and right)

II. Statement of the Physician (please mark "V" for an item that has been notified to the patient and "X" for an item that hasn't been notified to the patient)

1. I have tried my best to explain the information relevant to the surgery in a way that the patient can understand, particularly involving the following items:

- ☐ Reason for the surgery, steps, range, risk and success rate of the surgery and possibility of blood transfusion
- ☐ Surgical complications and possible treatments
- ☐ Possible consequence of not implementing the surgery and other alternative treatments
- ☐ Any temporary or permanent symptom that may occur after the surgery
- ☐ I have delivered the additional surgery-related descriptive information the patient if any

2. I have left sufficient time to allow the patient to ask questions related to the surgery and have answered the questions too:

（1）---

（2）---

（3）---

Signature of the Physician Responsible for the Surgery:

Date:______________________________

_____________________________ Time: ____(h) ____(m)

III. Statement of Patient

1. The physician has explained to me and made me fully understand the information relevant to necessity, steps, risk and success rate of the surgery.
2. The physician has explained to me and made me fully understand the risks of other alternative treatments.
3. The physician has explained to me and made me fully understand the possible prognosis of the surgery and the risk of not implementing the surgery.
4. I've understood blood transfusion may be necessary during the surgery; **I ☐ agree ☐ disagree with blood transfusion.**
   (Except for an emergent case as specified in Article 63 of the Medical Care Act.)
5. I have put up my questions and doubts regarding my condition, the surgery and treatment etc. and received replies.
6. I understand in case it is necessary to incise an organ or tissue during the surgery, the organ or tissue may be kept for a period of time in the hospital for the purpose of pathological analysis and report and the organ or tissue will be disposed discreetly as per relevant laws and regulations by the hospital.
7. I understand the surgery may be the most appropriate option at present but it cannot be ensured that the surgery would improve my condition definitely.

I agree with implementation of the surgery based on the statement above.

Signature of the Consenter: Relation with the Patient:___________

Tel: (0)__________________

Address:

Date:_______________________

Time: ____(h) ____(m)

Signature of the Witness: ☐ Witness is unnecessary, Signature:
Date:________________________

Time: ____(h) ____(m)

Remarks:________________________________

I. General Surgical Risks

1. Except for surgeries with local anesthesia, a small part of lungs may collapse and lose function during a surgery, resulting in an increase of the possibility of chest infection, which may require antibiotics and respiratory therapy.
2. Surgeries except for those with local anesthesia may cause vascular embolization accompanied by pain and swelling in legs. And coagulated blood clots may disperse and enter into lungs, causing a deadly danger; but such situation is not common.
3. Since the heart is under stress during a surgery, a heart disease or stroke may be induced.
4. Medical institutions and medical staff will try their best to provide a treatment and surgery to a patient; but the operation will not be necessarily successful and an accident that may even cause death still might happen.

II. The patient shall sign the field of "Signature of the Consenter" personally; but if the patient is a minor or unable to sign in the field personally, the person provided in Item 2, Article 13 of the Medical Care Act shall sign in the field <The Civil Law provides: an adult is a person whose age is 20 or above.>.

III. In case the consenter is not the patient, the relation between the consenter and the patient shall be filled in the field of "Relation with the Patient".

IV. As for the witness, the field may be left blank when there isn't any witness; but the box in front of "Witness is unnecessary" should be ticked and the person who ticks the box should leave a signature.

V. Any medical activity relevant to a plastic or cosmetic surgery that is not necessary medically must not be executed for minors under the age of eighteen in accordance with Item 4.1 of Article 28, Physicians Act of Republic of China, Taiwan. ◦

Description of Face Contouring Surgery (Template)

The description explains conditions of concerned patients and the purpose, method, benefit, possible complications, success rate and alternatives of face contouring surgery, possible problems during recovery and possible consequences without implementing the surgery, which can be used as reference for discussions between patients and physicians. Please discuss with your physician if you still have any doubt after the physician gives his/her explanation before you sign on the consent.

I、 Patient's Conditions:

Facial proportion abnormalities including square jaw or high malar. Face contouring surgery is a surgery for adjusting shape and size of facial bones and the surgical range commonly includes cheekbone and jawbone. In order to adjust facial proportions, face contouring surgery is used to move and reduce the position and size of cheekbone and jawbone through osteotomy and internal fixation.

II、 Purpose & Benefit:

Correction of relative maxillary/ mandible position. The surgery is most commonly used in treating the occlusion problem that cannot be improved with straightening of teeth simply due to some skeletal abnormality. Face contouring surgery can move the bones and teeth together to the most ideal position.

III、 Expected Benefits:

You may gain partial or whole benefits listed below through the surgery. But your physician cannot guarantee any one of the benefits for you. Furthermore it's your independent decision to take or not to take the surgical risk.

1. Facial proportion that inclines to a normal level
2. Facial symmetry that inclines to a normal level
3. Other:____

IV、 Possible Complications, Probability of Sequelae and Treatment (including but not limited to the following):

All surgeries are risky. The risk involves inoperative or postoperative temporary or permanent complications, some of which may even threaten lives of the patients. The risks listed below have been recognized; but there may be some unexpected risks that are not listed. Your physician will explain possible risks and treatments.

1. General complications:
   1) Wound bleeding
   2) Wound pain
   3) Wound swelling
   4) Wound infection, poor healing or tissue necrosis
   5) Risks of local or general anesthesia
   6) Reoperation may be necessary due to some complication or undesirable surgical result.
   7) Discomfort or infection risk (e.g. AIDS or hepatitis etc.) caused by blood transfusion that has been adopted as a necessary measure.
   8) Other:____

   ※ If you have or have just accepted or are accepting a chemotherapy at the site to be operated, have taken some immunosuppressive agent or anti-rejection drug for a long time, or suffer from malnutrition, a blood disease, diabetes, uremia, liver dysfunction, malignant tumor or another disease that may diminish your immunity; the possibility of wound infection will increase. If you are accepting or just have accepted a chemotherapy, have taken some anticoagulant, or suffer from diabetes, uremia,

liver function or a disease that may reduce blood coagulation, the possibility of bleeding will increase too. And if you are above the age of 60 or suffer from severe anemia, some cardiopulmonary disease or cardiopulmonary dysfunction etc., the anesthetic risk will increase.

2. Special complications:
   1) Inoperative hemorrhage
   2) Poor bone healing.
   3) Bruise of skin around lips and oral cavity
   4) Hypoesthesia of lower lip and skin at chin
   5) Numbness of skin at cheeks
   6) Gingival numbness
   7) Blurred speech
   8) Exposure of fixer inside bone
   9) Facial tissue prolapse
   10) The problem regarding psychology and social adaptation after facial contour is changed
3. Rare major complications:
   1) Osteonecrosis
   2) Optic nerve injury
   3) Facial nerve injury
   4) Numbness of skin at cheeks

V、 Alternatives:

Face contouring surgery is the radical way for adjusting proportions of facial bones. And treatments other than face contouring surgery for adjusting facial proportions are called as camouflage treatment. Although camouflage treatments cannot correct problem of facial bones completely, they still may achieve improvements of facial aesthetics to some extend. You may discuss about your decision and other options with your physician if you decide not to accept the surgery.

VI、 Questions from the Patient and Her Family:

(1)____

(2)____

(3)____

Patient (or Family/ Legal Representative):____________________(Signature & Seal)

□ I have understood the description stated above and agree to accept the face contouring surgery (please sign on the Consent to Face Contouring Surgery).

□ I have understood the description stated above and disagree to accept the face contouring surgery.

Relation with the Patient:__________________________(Required)

Physician for Explanation: ___________________________(Signature & Seal)

Date & Time: