Dear patient / legal representative;

You have the right to be informed about all kinds of medical, surgical or diagnostic procedures related to your health status / patient's health status and recommended to you / your patient, and their alternatives, benefits, risks and even possible harms, and to reject, accept or stop all / some of them at any stage.

This document, which we want you to read and understand, has not been prepared to frighten you or to keep you away from medical practices, but to inform you and obtain your consent in determining whether you will consent to these practices.

**INFORMATION**

PRE-DIAGNOSIS: .....

PLANNED TREATMENT/PROCEDURE: .....

NAME/SURNAME OF THE PHYSICIAN WHO WILL PERFORM THE PROCEDURE:

.....

**INFORMATION ABOUT THE PROCESS:**

If the material that can be obtained from the nose is insufficient or incomplete, this material is obtained from the ear or more from the rib bone, which we call costal cartilage. Whether it is cartilage taken from the cartilage behind the ear or from the rib, reshaping them and giving a new skeleton to the nose is a more difficult task than the first surgery, and of course, it will be a longer operation and a longer recovery period than the first surgery.

**EXPECTED BENEFITS FROM THE PROCEDURE:**

By correcting the shape of the outer part of the nose and correcting the part called the septum that divides the nose from the inside, it is aimed for the patient to breathe more easily. For this correction, a piece of your rib cartilage or auricle cartilage is taken.

**CONSEQUENCES THAT MAY BE ENCOUNTERED IF THE PROCEDURE IS NOT APPLIED:**

The deformity of the outer part of the nose and the problem of breathing through the nose will continue. There may be a risk of lung deflation-atelectasis due to the rib graft taken, and skin infections.

**ALTERNATIVES TO THE PROCEDURE:**

Spray treatments can be used to relieve nasal congestion. However, although these drugs eliminate mucosal problems, they may not be a solution because they will not eliminate the curvature of the outer and inner parts of the nose, which anatomically causes nasal congestion.

**RISKS AND COMPLICATIONS OF THE PROCEDURE:**

• Abnormal healing of external wounds (due to abnormal scar formation)
Adhesions or scar tissue formation in the nose may require another surgery in the future.
• Loss of sensation in the upper part of the lip and/or upper front teeth
• A hole may occur in the thin wall (septum) in the middle of the nose. This is usually not a big problem. Sometimes it can cause whistling, crusting, bleeding. Further surgery may be required.

**POINTS THAT THE PATIENT SHOULD PAY ATTENTION TO BEFORE AND AFTER THE PROCEDURE:**

Your doctor will inform you about the points you need to pay attention to before and after the procedure.

**PROBLEMS THAT MAY OCCUR IF YOU DO NOT PAY ATTENTION TO THE ISSUES TO BE COMPLIED WITH:**

Your doctor will inform you about the problems you may experience if you do not pay attention to the issues to be followed.

**ESTIMATED TIME OF THE TRANSACTION:**

The Estimated Time of the Procedure can take an average of 3-4 hours. However, depending on the patient's nose structure and the nature of the surgery to be performed, the surgery may end earlier or later.

**POSSIBLE UNDESIRABLE EFFECTS OF THE DRUGS TO BE USED AND ISSUES TO BE CONSIDERED:**

Use the medicines recommended by your doctor in accordance with the instructions for use. Your doctor will inform you about the possible undesirable effects of the drugs and the issues to be considered.

**HOW TO GET MEDICAL HELP ON THE SAME SUBJECT WHEN NECESSARY:**

Not accepting treatment/surgery is a decision you will make of your own free will. If you change your mind, you can personally re-apply to our hospital(s) that can perform the treatment/surgery in question.

**Phone:** 0850 811 3400

**Medical research:** I consent to the review of clinical information from my medical records for the advancement of medical study, medical research and physician education, provided that the patient confidentiality rules in the patient rights regulation are adhered to. I consent to the publication of research results in the medical literature as long as they protect patient confidentiality. I am aware that I may refuse to participate in such a study and that this refusal will not adversely affect my treatment in any way.

**ASSENT**

I have read the information described above and have been informed by the undersigned physician. I was informed about the purpose, causes and benefits, risks, complications, alternatives and additional treatment interventions of the treatment/procedure to be performed. I consciously approve this transaction without any additional explanation, without any pressure.

When I lose consciousness in any way or am unable to give consent in the interventions to be made to me regarding my treatment, I ..... to give approval and to receive all kinds of information about my treatment I authorize the person named (The person authorized by the patient must sign as the patient's attorney / legal representative).

I accept the application of Turkish Law and the jurisdiction of Istanbul Courts in legal disputes that may arise as a result of the treatment I have received at BHT CLINIC Istanbul Tema Hospital.

Patient Signature Date / Time of Consent
Name-Surname (handwritten)
……. ……/……/…… ……:……

If the patient is unable to give consent:

Patient / legal representative Signature Date / Time of Consent

Name and Surname (handwritten)..... ……/……/…… ……:……

The reason for the patient's inability to give consent (to be filled in by the physician):
……
……

Adequate and satisfactory explanations have been given by me to the above-named patient/legal representative about the disease, the treatment/procedure to be performed, the purpose, cause and benefits of this treatment/procedure, the care required after the treatment/procedure, the risks and complications of the treatment/procedure, the alternatives of the treatment/procedure, the type of anesthesia to be applied if necessary for the treatment/procedure, and the risks and complications of anesthesia. The patient/legal representative has signed and approved this form with his own consent that he has been adequately informed about the treatment/procedure.

The Physician Who Will Perform the Treatment/Procedure
Name Surname:.. ……..…
Title:.....

Signature Date / Time
……/……/…… ……:……

**If the patient has a Language / Communication Problem;**

I translated the explanations given to the patient by the doctor. In my opinion, the information I have translated has been understood by the patient.

Translator's Signature Date / Time

Name and Surname (handwritten) : ..... ...../...../..... .....:.....

You can apply to the Patient Rights Unit during the day and to the Supervisor/Night Administrative Supervisor at night for all your complaints about medical practices or any issue you want to mention.

*Legal Representative: Guardian for those under guardianship, parents for minors, 1st degree legal heirs in their absence. Signing this consent document does not remove the patient's legal rights.