Patient Name-Surname:

Date: Protocol No:

GENERAL INFORMATION

The purpose of this form is to make you aware of your health and to participate in the decision to be made. Although this form has been explained to meet the needs of most patients in many circumstances, it should not be considered as a document containing the risks of all treatment modalities. Depending on your personal health condition, your physician may give you different or additional information.

After you have learned about the benefits and the possible risks of diagnosis, medical treatment, and surgical interventions, it is up to you to decide whether or not to accept the applications to be made. Except in cases of legal and medical obligations, you may refuse to receive information or withdraw consent at any time.

What is Nipple Reconstruction?

It is breast reconstruction for patients who have lost their breast due to cancer or other reasons.

Information on the Operation

There are different methods to regenerate the brown area called areola at the nipple and its surroundings. Skin patches taken from other parts of the body, tissue shifting from the breast skin to the nipple or sharing the tissue from the other nipple can be used. Other techniques may be applied, for example, for the purpose of delivering the tattooing to the tissue.

Nipple reconstruction can be planned as a single surgical intervention, or it can be performed together with other breast surgeries.

Possible Risks

Each surgical procedure has a certain amount of risk, and the important thing is that you understand those related to nipple reconstruction surgery. It is essential to compare the risks and benefits of the intervention in choosing a surgical intervention. Even if many patients do not experience the following complications, discuss the risks, possible complications, and consequences with your physician until you are sure that you understand them.

- Bleeding: Although rare, it is possible to encounter a bleeding during or after surgery. When bleeding

occurs after surgery, the accumulated blood (hematoma) may need to be drained urgently. Do not take aspirin or painkillers starting ten days before the surgery, as this increases the risk of bleeding.

- **Infection:** Infection is not common after this type of surgery. If infection develops, treatment with antibiotics or additional surgical intervention may be required. Following nipple reconstruction surgery, skin patch loss or nipple loss due to infection is possible.

- **Scars on Skin: Excessive scarification is not common. In rare cases, abnormal scars may occur. The scars may be ugly and of a different colour than the surrounding skin. These scars** may develop **both** in the area of **nipple** reconstruction and in the area where tissue is taken for this procedure. Additional surgical intervention may be required after surgery for abnormal scarification.

- **Skin Graft (Burning): Skin grafts are used in some nipple** reconstruction techniques. Scarring, poor healing or abnormal discoloration may be observed in the localization where the graft is taken. Chronic itching sensation has been reported. Graft may be lost due to infection or other reasons; additional skin grafts may be needed.

- **Hair Development:** Skin grafts used in **nipple** reconstruction may contain hair roots, and there may be hair growth at the reconstructed nipple. Additional treatment may be required for the removal of hair roots.

Diagnosis:..... The treatment/procedure to be performed**……**

If appropriate, side/level information □ Right □ Left □ Two-sided Level…….

If you do not want to be informed about the purpose, duration, wounds, chance of success, recovery process, possible risks and complications, alternative methods and situations that may be encountered in case of refusal of treatment, please indicate in writing.

……

PERSONAL INFORMATION

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……..

Medications used: Bleeding Time:

Allergy: Other Diseases:

I consent that clinical information of my medical records can be reviewed to advance medical study, medical research, and physician's education, provided that it is adhered to the rules for patient privacy in the Patients' Rights Regulations. I consent that the results of the research can be published in the medical literature as long as the patient's identity is retained. I am aware of the fact that I have the right to refuse the participation in such a study and this refusal will not negatively affect my treatment in any way.

Photograph/ Observers: I certify that the surgery to be performed can be photographed or videotaped, including the appropriate parts of my body, for scientific, medical, or educational purposes, provided that the images do not reveal my identity. At the same time, I acknowledge that the qualified observers can get in the operating room during the surgery for developing medical education. I have read and understood the content of the clarified consent form. All the gaps in this form were filled out before I signed it and I received a copy of it.

Patient's Consent:

My physician has informed me about my disease;

how the operation will be performed, its purpose, duration, benefits, chance of success, there may not be a guarantee to improve the current situation, the recovery process, possible risks and complications, alternative methods, situations that I may encounter if I do not accept the treatment, and if necessary, an additional surgery/intervention/application can be performed. He/she has answered all my questions about these issues.

We declare that we are aware that we take the responsibilities in this regard, and we accept and consent to the surgery without any violence, suggestion, material, or moral pressure.

I know that medical devices such as X-ray, scopy, ultrasonography, scintigraphy, computerized tomography, magnetic resonance etc. may need to be used during interventions, that I may be exposed to radiation that may have negative effects on my health in some of these devices / applications and I approve the use of these medical devices if deemed necessary.

I know that a different condition that has not been experienced before may develop very rarely during the operation and in this case, I also allow and approve the interventions that the procedure team deems appropriate.

I sign this form without the need for additional explanation, under no pressure and consciously.

Patient Name / Surname: Date/Time:

Signature:

or

Patient Guardian/Relative Date/Time:

Name - Surname: Signature:

(Degree of relationship ……..)

Translator (If Needed) Date/Time:

Name - Surname: Signature:

Adequate and satisfactory explanations have been made by me to the patient/patient relative whose name is written above about the disease, the intervention to be performed, the reasons and benefits of this intervention, the care required after the intervention, the expected risks, the type of anesthesia to be applied if necessary for the intervention and the risks and complications of anesthesia. The patient/patient relative has read and signed this form with his/her own consent stating

Name and Surname of the Physician: Date/Time:

Signature: