



**CONSENT FORM**  
**FOR**  
**RELIEF OF CONTRACTURE**  
**Z-PLASTY ± SKIN GRAFT**

Med Rec. No.....

Surname:.....

Forename: .....

DOB:.....

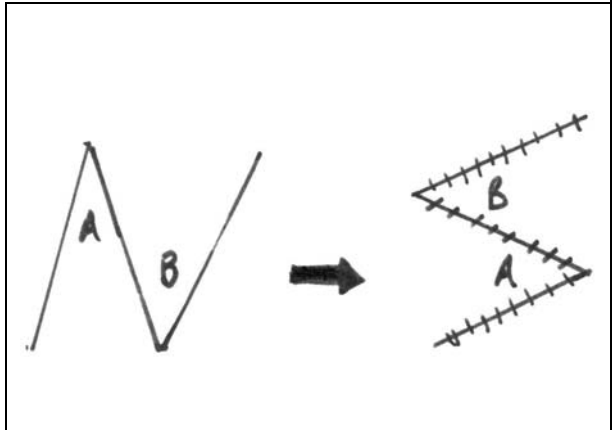
AFFIX LABEL HERE

**PROPOSED TREATMENT**

The doctor has explained that I, (*name of patient*) ..... have a **contracture** of the .....(*location/side*) due to..... and that the **contracture** could be **relieved using Z-plasty ± full thickness skin graft**:

This means using plastic surgical techniques to re-fashion and relax the tight wound tissue and preserve or improve movement of the affected joint(s). The aim of the operation is to lengthen the scar and increase the movement of the joint nearby.

Under a general anaesthetic, the thickened scar tissue is cut away. The wound is then lengthened by adding new cuts on each side of the wound to make small triangular flaps of skin. These are rearranged to cover the wound at a different angle, giving the new scar a Z shape. If the new wound cannot be closed completely in this way, a full thickness skin graft can be used to fill defects.



If a skin graft is needed, a suitable donor site is chosen, so the colour and nature of the skin is as good a match as possible and the skin cleansed. The graft is cut, placed on the recipient wound site and bandaged into place. The donor site is then closed with stitches and dressed.

**RISKS**

*These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your plastic surgeon if you have any general or specific concerns.*

I understand there are risks associated with any **anaesthetic** (see separate *Anaesthetic Consent Form*).

I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand **relief of contracture using Z-plasty** has the following **specific risks and limitations**:

- I will have a visible wound, although this will fade in time. The final results of the operation will not be apparent for some weeks/months.
- Full movement of my affected joint(s) may take some time and effort to recover; in a few cases, my pre-injury range of movement may never be fully regained.
- My wound may become infected, delaying healing.
- My new scar may heal with further thickening and shortening.

If **full-thickness skin grafts** are required, these have the following **specific risks and limitations**:

- My graft may fail to take and further treatment may be required.
- If any of my operation sites becomes infected, healing will be delayed and the damage may be deepened.
- My recipient wound or donor sites may heal with scarring, which may contract in time and limit movement if the scar is located across a joint.

I understand some of the above risks are more likely if I am overweight or have other medical conditions.

**INDIVIDUAL RISKS**

I understand the following are possible significant **risks and complications specific to my personal circumstances**, that I have considered in deciding I will have this operation:

.....  
.....

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**DECLARATION BY PATIENT**

- I acknowledge the plastic surgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the plastic surgeon any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my plastic surgeon during this operation.
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I understand that a doctor other than the specialist plastic surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If any staff member is injured or exposed to my blood or other body fluid then I give my consent to a sample of my blood being collected for the purpose of testing for infectious diseases, such as Hepatitis B, C and HIV. I understand that no testing of the blood sample will be carried out without prior discussion and my explicit consent.

Signature of patient  Date

*If the patient is unable to give consent, a proxy form must be completed*

**DECLARATION BY DOCTOR**

- I declare that I have explained the nature of the condition, the procedure to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature

Doctor's name  Date   
*(please print)*

**INTERPRETER'S DECLARATION** - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's signature  Date

Interpreter's name   
*(please print)*