BREAST IMPLANT REMOVAL

I authorize and direct _____**,** M.D., with associates or assistants of his or her choice, to perform the following procedure of breast implant removal on _____.
(patient name)

☐*right breast* ☐*left breast*

Patient's Initials

_____ The details of the procedure have been explained to me in terms I understand.
_____ Alternative methods and their benefits and disadvantages have been explained to me.
_____ I understand and accept the most likely risks and complications of breast implant removal include but are not limited to:

- *Strong, negative impact on my physical appearance, including distortion, wrinkling, and significant loss of volume, and/or an appearance worse than prior to the initial augmentation*
- *Severe psychological disturbance, including depression*
- *Loss of interest in sexual relations by either myself or my partner*
- *Scar contractures precluding reconstruction later*
- *Infection, hematoma (swelling or blood mass), or scarring*
- *Loss of breast tissue resulting in loss of breast sensation*
- *Inability to breast-feed*
- *Implant rupture and inability to remove 100% of the residual silicone from the breast cavity*

_____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
_____ I understand and accept the risks of blood transfusion(s) that may be necessary.
_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.
_____ I am aware that smoking during the pre- and post-operative periods could increase chances of complications.
_____ I have informed the doctor of all my known allergies.
_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
_____ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.
_____ I am aware and accept that no guarantees about the results of the procedure have been made.
_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
_____ I understand that the removed implant will be examined and sent to pathology, if necessary.
_____ I understand that if the implant is intact, I may take it with me, or it will be destroyed.
_____ Plastic surgery is not an exact science. On occasion there are instances when revisional surgery may be required to obtain maximum desired results. There may be additional minor fees associated with a touch-up/revisional surgery. This is reviewed on a case-by-case basis.
_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____ _____
Patient or Legal Representative Signature / Date Relationship (self, parent, etc.)

_____ _____
Print Patient or Legal Representative Name Witness Signature / Date

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the *patient / legal representative* fully understands what I have explained.
(circle one)

_____
Physician Signature / Date

_____ copy given to patient _____ original placed in chart
initial initial

07/09