REDUCTION MAMMOPLASTY
(Breast Reduction)

Breast reduction is usually performed to relieve back, neck, and shoulder pain, and skin irritation, that women with large breasts sometimes experience, rather than to enhance the appearance of the breast. The best candidates for this procedure are those who are mature enough to understand and have realistic expectations about the results.

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

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

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 possible risks and complications include but are not limited to:

- *asymmetry*
- *bleeding*
- *change in nipple and skin sensation*
- *delayed healing*
- *different size than expected*
- *discoloration/swelling*
- *discomfort (pain/sensitivity)*
- *failure to improve symptoms*
- *infection*
- *nipple retraction/poor contour*
- *restricted activity*
- *skin, nipple, flap loss*
- *unsatisfactory results*
- *wound separation*

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with any surgical procedure.
_____ 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 any other.
_____ I have been advised whether I should avoid taking 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 post-operatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
_____ I understand that any tissue/specimen removed during the surgery will be sent to an outside pathology facility for evaluation and I also understand that I am responsible for payment to that outside facility for these services.
_____ The doctor has answered all of my questions regarding this procedure.
_____ Pre- and post-operative photos and/or videos will be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending physician.

continued

_____ 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.

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*** *(circle one)* fully understands what I have explained.

_____

Physician Signature / Date

_____ copy given to patient
initial

_____ original placed in chart
initial