

BROWLIFT SURGERY

Browlift surgery is meant to improve the appearance of drooping eyebrows, eyelid hooding, forehead furrows, and frown lines. There are two surgical methods; the first is the most conventional method where a surgical incision is hidden just above the hairline. The second is performed using an endoscope, which enables the procedure to be performed with a minimal number of incisions. While the traditional method can sometimes attain more lift, both methods can create smoother, flatter skin on the forehead.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform the following procedure of _____ browlift on _____
traditional or endoscopic

(patient name)

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 browlift surgery include but are not limited to:
- *Bleeding*
 - *Scarring*
 - *Allergic reaction to tape, sutures or topical preparations*
 - *Pain*
 - *Weakness or paralysis of the muscles and nerves that elevate the brow or close the eye*
 - *Asymmetry of the eyebrows (often present preoperatively)*
 - *Possible diminished or absent sensation to the forehead or scalp (often temporary)*
 - *Fluid under the skin (seroma/hematoma)*
 - *Ridging of the scalp skin*
 - *Lumps/irregularities under the skin that may resolve over a few months*
 - *Itching of the scalp*
 - *Skin loss requiring further reconstructive surgery*
 - *Infection or accumulation of blood requiring evacuation*
 - *Irritation or dryness of the eye (often temporary)*
 - *Mild residual frown lines*
 - *Hair loss or thinning around incisions*
 - *Unsatisfactory result*
- _____ 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 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.
- _____ (For Endoscopic Browlift only) I understand that if my doctor becomes concerned during the course of the procedure he/she may find it necessary to create a standard forehead incision (“coronal” or ear-to-ear across the top of the head) in order to correct the problem.
- _____ I understand the coronal incision(s) may result in some numbness and itching of the upper scalp that may slowly resolve over several months.
- _____ I understand the coronal incision(s) may result in patchy numbness that may be permanent.
- _____ I understand the coronal incision(s) will result in a permanent scar.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ 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 and will be used for medical record purposes only.
- _____ 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.
- _____ The doctor has answered all of my questions regarding this procedure.
- _____ 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 Signature / Date

Witness Signature / Date

Print Patient Name

Print Witness Name

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 fully understands what I have explained.

Physician Signature / Date

_____ copy given to patient
initial

_____ original placed in chart
initial