

MASTOPEXY

(Breast Lift)

Mastopexy, or breast lift, is a surgical procedure to raise and reshape sagging breasts by removing excess skin and repositioning remaining tissue and nipples. Mammograms and a routine breast exam are required prior to surgery.

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, including the possible use of implants.

_____ I understand and accept possible risks and complications include but are not limited to:

- Additional surgery
- Allergic reactions to tape, suture material, topical preparations
- Asymmetry of breasts and/or nipples
- Bleeding
- Change in nipple and skin sensation
- Delayed healing
- Discomfort (pain/sensitivity)
- Excessive firmness of breast
- Infection
- Permanent and noticeable scarring
- Permanent loss of feeling in nipples or breasts
- Recurrence of sag
- Re-operation required
- Skin or nipple/areola loss
- Sores or numbness around nipples
- Temporary bruising

_____ I am not pregnant at this time.

_____ I understand pregnancy may cause my surgical result to change after delivery.

_____ I understand that the duration of results are variable: gravity, pregnancy, aging and weight change will continue to affect the breasts over time.

_____ 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, etc.

_____ 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 or implied.

_____ 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.

continued

- _____ 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.
- _____ Pre- and post-operative photos will be taken of the treatment for record purposes. I understand that these photos will be the property of the attending physician and remain with my record.
- _____ 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 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