

BREAST AUGMENTATION

*Breast augmentation is accomplished by inserting a breast implant either behind the breast tissue or under the breast muscle in order to enlarge their size. Breast implants do **not** have an indefinite life span, regardless of type, and may eventually require replacement surgery.*

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

Patient's
Initials

_____ The details of the procedure have been explained to me in terms I understand including but not limited to:

- *Location of implant - subglandular vs. submuscular*
- *Location of incisions*
- *Preferred technique and why*
- *Available methods of anesthesia*
- *Type of implant to be used – including manufacturer warranty*
- *Anticipated size and shape*
- *Constraints of individual anatomy*
- *If asymmetry exists, complete correction unlikely*

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I understand and accept the most likely risks and complications include but are not limited to:

- *Ability to feel the implant*
- *Asymmetry*
- *Bleeding or hematoma formation*
- *Capsular contracture (firmness)*
- *Change in nipple sensation including numbness*
- *Malposition of an implant*
- *Rippling appearance of skin*
- *Rupture/leakage requiring replacement*
- *Uncertain life span of implant*

_____ I understand and accept the less likely risk and complications include but are not limited to:

- *Chronic pain*
- *Compromised detection of early breast cancer*
- *Infection that may require removal of implant*
- *Pneumothorax (air in chest)*
- *Possibility of late calcification*
- *Possible effects on breastfeeding*
- *Unsightly scarring*

_____ I understand and accept the even 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 postoperative periods increases the risk 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, and any other recreational drug or alcohol use.

_____ 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 accept financial responsibility for revisions or complications.

_____ 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.

- _____ 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 may not be used publicly without my express permission.
- _____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
- _____ 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/revision surgery. This is reviewed on a case-by-base basis.
- _____ The doctor has answered all of my questions regarding this procedure.

Patients must be off all aspirin-containing products (including ibuprofen) for 2 week(s) before surgery. I understand that many over-the-counter remedies contain aspirin and that I am responsible for avoiding them.

For patients over age 35, there is a need for initial mammography prior to breast implantation.

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