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 _______________________________________.

☐ 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 understand and accept that no guarantees about the results of the procedure have been made.

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

Physician Signature / Date

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

07/09