



CONSENT FOR SURGICAL AND SUCTION-ASSISTED FAT REDUCTION

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Patient Name: _____ Chart No.: _____ Date: _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

I have been informed that I have the following conditions: _____

The procedure(s) to treat those conditions has/have been described as: _____

- _____ 1. Suction-assisted lipectomy is the surgical technique used to remove localized collection of fat beneath the skin. I understand that the purpose of my surgery is to attempt to improve the appearance of localized areas on my body.
- _____ 2. I have been completely candid and honest with my doctor regarding my motivation for undergoing liposuction, realizing that a new appearance does not guarantee an improved life.
- _____ 3. I have provided my doctor with a complete and accurate medical and social history, realizing that withholding certain information may adversely affect my diagnosis and treatment and the final result of my surgery.
- _____ 4. It has been explained to me that suction-assisted lipectomy is a surgical technique suitable for selected patients. It is not a substitute for weight reduction that can ordinarily be obtained by dieting and exercise, and it is not a cure for obesity.
- _____ 5. It has also been explained to me that my physical condition may require surgical lipectomy in which excess skin and fat may be removed instead of, or in addition to, suction-assisted lipectomy.
- _____ 6. If I use tobacco, I understand that this could complicate surgery, anesthesia, healing, results, and longevity.

SURGICAL CONSIDERATIONS

- _____ 7. The technique of liposuction has been explained to me. I understand that it may be performed under local anesthesia or in conjunction with the use of intravenous sedation or a general anesthetic. Small skin incisions are made in selected locations, through which a blunt, tubular instrument (catheter) is inserted to suction fat deposits from beneath the skin. I have been advised that additional or larger incisions may be necessary to gain adequate access to all areas of unwanted fat.

POST-OPERATIVE CONSIDERATIONS

- _____ 8. All incisions will be closed with small sutures; however, slight scarring may be expected. I have been advised that in some patients, scarring is unpredictable and may be more noticeable. If necessary, a secondary procedure may be performed to attempt to minimize scarring.
- _____ 9. After surgery a snug dressing of elastic gauze will be applied to the surgical areas to help conform the skin to the shape of the underlying tissues. This pressure bandage will be in place for about two weeks. Some bruising and swelling may persist for several weeks after surgery. Some post-operative discomfort can be expected and medications will be prescribed to provide adequate relief.

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POST-OPERATIVE CONSIDERATIONS Continued...

- _____ 10. I have been advised and understand that patients react differently to liposuction, depending upon age and health. Some individuals have different skin elasticity and may require additional procedures to remove or tighten excess skin. Further, some patients' skin may tend to wrinkle more than others.
- _____ 11. I will avoid strenuous physical activity, exercise, etc. for at least two weeks after surgery.

RISKS AND COMPLICATIONS

- _____ 12. My doctor has explained to me that there are certain inherent and potential risks in any surgical treatment, and that in this specific instance such operative risks include, but are not limited to:
- _____ A. The possibility of a second surgery/procedure in the event an abundance of excess fat is encountered.
 - _____ B. Ordinarily, liposuction of the face and neck does not cause excess bleeding that would require blood transfusion. Nevertheless, there is the remote possibility of blood transfusion and I understand that I may donate my own blood before surgery so that it may be transfused back to me if necessary.
 - _____ C. I understand that surgery involves the risk of numbness of the skin overlying the area of fat removal. In most cases, this condition is temporary, but in rare cases may be permanent.
 - _____ D. It is possible that after fat removal the overlying skin will not be smooth, but may appear to have a "wash-board" appearance. A second liposuction or other cosmetic procedure may be necessary to attempt correction of this condition.
 - _____ E. In the event fat is to be removed from the cheek area, I have been advised that there is a possibility of injury to the nerves that control the muscles of facial expression, causing a loss of facial tone and decreased function. This condition is usually temporary, but may be permanent.
 - _____ F. Any surgery involves the risk of infection that may require antibiotic treatment. Most infections resolve without complication, but, in rare instances, treatment may involve hospitalization and may affect the planned outcome of the surgery.
 - _____ G. There is a possibility of localized collection of blood (hematoma) in the areas of fat removal. Secondary surgical procedures may be necessary to drain those areas.
- _____ 13. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis), which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.
- _____ 14. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult who will drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
 - B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
 - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
 - D. **However**, it is important that you take any regular medication (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

NO GUARANTEE OF TREATMENT RESULTS

- _____ 15. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or meet every expectation. Due to individual patient differences, there is a risk of failure or relapse, my condition may worsen, and selective re-treatment may be required in spite of the care provided.
- _____ 16. I have had an opportunity to discuss my medical and social history, including drug and alcohol use, with my doctor. I have informed him of all aspects of my health history, recognizing that withholding information may jeopardize the planned goals of surgery.
- _____ 17. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that any lack of cooperation can result in a less than optimal result, or may be life threatening.
- _____ 18. If any unforeseen condition should arise during surgery which may call for additional or different procedures from those planned, I authorize my doctor to use surgical judgment to provide the appropriate care.
- _____ 19. Revision surgery, although rare, is a possibility with any cosmetic procedure. Post operative touch ups are usually minor and most often performed with local anesthesia. A surgical fee will be charged commensurate with the extent of the revision.

INFORMATION FOR FEMALE PATIENTS

- _____ 1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return to the use of birth control pills.

Buccal Fat Reduction

The buccal fat pads lie on each side of the cheek and extend from the temple to the lower jaw. Reduction of this fat is a common procedure to slim the face. This is a moderate result and not a procedure that will duplicate a major body weight loss. The goal of this surgery is to reduce the cheek fat in a subtle manner. It is important not to take out all the fat, but rather to provide a reduction. The area that is affected by the surgery is the lower cheek that is lateral to the corners of the mouth and the result is generally not noticeable in the high cheek or temple regions.

Risks and Complications

- _____ 1. The anticipated result in a minor to moderate reduction of the cheek fat.
- _____ 2. I understand that this will not be the same result as a major weight loss.
- _____ 3. I understand that although rare, this surgery can result in permanent or temporary facial nerve damage that could result in movement or sensation changes.
- _____ 4. I understand that the parotid duct (the tube that drains saliva into the mouth) could be damaged and result in salivary gland or saliva retention and require additional surgery to repair.
- _____ 5. I understand that bleeding or infection can result and result in the necessity of further treatment.

_____6. I understand that excessive removal of fat could result in a hollow now or in the future and could require further treatment.

_____7. I understand that the final result may not be as dramatic as I desire and that lack of result or asymmetry may result.

CONSENT

I certify that I have had an opportunity to fully read the terms of this consent, and that all blanks or statements requiring insertions were filled before my signing. I also certify that I speak, read and write English. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient's Signature

Date

Doctor's Signature

Date

Witness' Signature

Date