Lexington Plastic Surgery

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REDUCTION MAMMOPLASTY (BREAST REDUCTION)

REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGNTHIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT: _____DATE: ____/_____/_____ I

understand that the above named procedure has been explained and is to be performed on me.

The following has been explained to me in general termsand I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is mammary hypertrophy/hyperplasia (disproportionately large and heavy breasts).

2. The **NATURE OF THE PROCEDURE** is to reduce the size and reshape the contour of large breasts byremoving excess breast skin and underlying breast tissue.

3. The **PURPOSE OF THIS PROCEDURE** is to establish more natural breast proportions, better symmetry, correct excess sagging and relieve back, neck and shoulder pain if due to the weight of the breasts. Breast reduction makes the breasts easier to examine physically and by mammography.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances ofmy medical condition. Other practical alternatives include weight reduction, however breast tissue is usually not affected byweight lossand exercise. Support garmentsmay help but do not correct the basic problem. Suction lipectomy removes fatbut usually no glandular tissue.

5. **IF I CHOOSE NOT TO HAVE THE ABOVE NAMED PROCEDURE, MY PROGNOSIS (future medical condition)** is not completelypredictable and the medical condition may get better, may get worse or maystay thesame.However, failure to have the procedure may result in possible progression of the medical condition and/or thepossibleneed for moreextensive surgery if the medical condition progresses and remains undiagnosed or untreated.Diet, exercise, pregnancy, aging and health problems may all contribute to future changes in mymedical condition.

6. **MATERIAL RISKS OF THIS PROCEDURE:** As a result of this procedure being preformed, there may be material risks of: INFECTION, ALLERGIC REACTION, TOXIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTIONOF ANYLIMB OR ORGAN, BRAINDAMAGE, CARDIAC ARREST OR DEATH.

7. In addition to thesematerial risks**,** there may be **OTHER POSSIBLE RISKS** involved in this procedure including but not limited to:

   1) loss of function (inability to breast feed);

   2) nipple/areola may intentionally be made smaller;

   3) loss of pigmentation in the skin, nipple or

   areola Initials _____ (person signing)

7. **OTHER POSSIBLE RISKS (concluded):**

4) nipple retraction;

5) sensitivity in the breast and nipple may be reduced and numbness (sensory loss, loss of feeling), itching, firmness, lumpiness and tight feelings may occur and could be temporary or permanent;

6) a hematoma (blood clot or collections of bloody fluid) may occur at the operative site;

7) severe blood loss may occur which may necessitate transfusion which carries the risk of exposure to AIDS, hepatitis or other infectious diseases;

8) emboli or clots of blood and/or other material may go into the blood stream and travel to other parts of the body including the lungs or brain causing illness or even death;

9) infection and/or abscess formation (collection of pus) may occur;

10) some tissue may slough (dissolve away) due to poor healing;

11) skin loss may occur (more common in smokers);

12) loose skin may result;

13) if opposite sides are treated, the result may not be symmetrical (equal on both sides);

14) some fatty tissue may undergo fat necrosis (dissolve away) which may cause lumpiness or firmness in the tissue and may sometimes require drainage;

15) fluid collections may accumulate under the skin and may require drainage or aspiration (withdrawal by needle);

16) pain and discomfort may occur;

17) scars will occur and may go from pink and firm to faded and soft over a period of six to twelve months; some scars may widen, become depressed, or appear raised, firm and "ropey" red which may take two years or longer to fade and soften; scars will be PERMANENT AND VISIBLE;

18) bruising and swelling may occur and last a few weeks to several months;

8. Even though the risks and complications cited above are infrequent, they are the ones peculiar to the operation and are of greatest concern. Complications may also be increased due to the patient's individual medical condition and personal habits. Medications, i.e. **ASPIRIN,** may interfere with blood clotting and cause excessive bleeding. **SMOKING CIGARETTES** may interfere with the blood supply to the skin and may cause abnormal healing with tissue sloughing (dissolving away) and excessive scarring. **ALCOHOL** may cause excessive bleeding during and after surgery. Certain **HERBAL PREPARATIONS** may affect the blood clotting system and cause excessive bleeding while others may inhibit healing of the incisions. Colds, infections, boils and pustules may increase the risk of infection after surgery. Excessive sun exposure and/or tanning beds, heating pads and hot water bottles may cause severe burns at the surgery site if one has temporarily or permanently lost protective sensation.

9. There is no increase or decrease in the incidence of breast cancer following reduction mammoplasty. Follow-up for breast cancer detection will need to continue life long. Twice a month self breast exams should continue and annual breast examination by my surgeon or primary care physician is recommended.

Initials _____ (person signing)

A mammogram may be recommended prior to surgery to determine if any areas of suspicion are present that should be biopsied (removed and examined microscopically) prior to or during surgery. A mammogram is usually recommended approximately one year after breast reduction surgery to establish a baseline for later reference according to the American College of Surgeons' guidelines.

10. I understand that the physician, medical personnel and other assistants will rely on statements made by me concerning my medical history and other information I provide in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure, which has been explained to me. Withholding medical and/or health information may result in further complications.

11. There may be a need for immediate or other additional surgery to treat the above complications, which could include hospitalization, time off work and additional expense to me.

12. I understand that my expectations should be realistic and I should consider not undergoing the surgery if my expectations are greater than the reality of this treatment. Psychological problems may occur due to unrealistic expectations of the surgery or difficulties in accepting changes in my appearance.

13. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE.

14. I consent to the taking of pictures during the course of my treatment for the purpose of helping to plan and assessthe proposed therapy. No photographs will be shown to patients or physicians without my permission. Ifany portion of my surgery is to billed to insurance (this does not include cosmetic procedures), I understand myinsurance carrier may require photographs to process my claim.

15. On occasion, surgical revisions may be indicated following the original surgery. If planned or performed within one (1) year after the original surgery, there will be no charge by the surgeon. However, a fee will be charged by the facility for use of the operating room. There will also be a charge by the anesthesiologist if indicated.

16. I voluntarily consent to allow Dr. Gerstle and all medical personnel under his direct supervision and control and all other personnel whomay otherwise be involved in performing such procedures to perform the procedure(s) described or otherwise referred to herein.

17. BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN.

Signature of person giving consent: _____ Date: _____

Relationship to patient if not the patient: _____

Witness: _____ Date: _____

_____ Copy of consent form offered to patient

_____ Copy given _____ Declined