Lexington Plastic Surgery

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BROW LIFT - FOREHEAD LIFT

REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGN THIS 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 terms and I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is low or droopy brows and/or wrinkled forehead.

2. The **NATURE OF THE PROCEDURE** is to tighten the skin above the brows in an attempt to raise low, sagging brow positions and/or lessen wrinkles in the forehead. This may be done by incisions (cuts) across and above each eyebrow or by a large incision across the top of the head from one ear to the other. Skin (or scalp) is taken out to tighten the skin and sometimes the muscles of the forehead are changed. Alternatively, the brow may be lifted using an endoscope which is a lighted surgical telescope to reach down to the level of the eyebrows from several incisions located high on the forehead or within the hair. The muscles may be altered and then the brow is suspended in an elevated position.

3. The **PURPOSE OF THIS PROCEDURE** is to attempt to make the eyebrow position and shape more pleasing and sometimes to diminish wrinkles in the forehead.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. There is not a good substitute for surgery. Sometimes a chemical peel (painting the skin wfth a combination of ingredients), dermabrasion (sanding the skin), Retin-A, moisturizers or cosmetics (makeup) may improve wrinkle lines.

5. **IF I CHOOSE NOT TO HAVE THE ABOVE NAMED PROCEDURE, MY PROGNOSIS (future medical condition)**is not completely predictable and the medical condition may get better, may get worse or may stay the same. However, failure to have the procedure may result in possible progression of the medical condition and/or the possible need for more extensive 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 my medical condition.

6. **MATERIAL RISKS OF THIS PROCEDURE:**As a result of this procedure being performed, there may be material risks of: INFECTION, ALLERGIC REACTION, TOXIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.

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

   1) thinning of the hair which may be temporary or permanent;

   2) scars in the scalp will not grow hair and there may be hair loss around the scars;

Initials_______(person signing)

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

3) the muscles of expression in the forehead (to lift the eyebrows) may become paralyzed temporarily or permanently and may not work the same as before surgery; movement of the eyebrows may not be equal or balanced due to paralysis of the forehead muscles;

4) improvement from surgery may change or be lost as time passes;

5) there may be a change in the appearance of the upper eyelids;

6) the eyebrows may not be symmetrical (equal and balanced on both sides);

7) there may be temporary or permanent numbness in the forehead and/or scalp;

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

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

1O) fluid collections may accumulate under the skin and may require drainage or aspiration (withdrawal by needle);

11) pain and discomfort may occur;

12) numbness (sensory loss, loss of feeling), itching, firmness, lumpiness and tight feelings may occur and could be temporary or permanent;

13) scars <u>will</u> occur and may go from pink and firm to faded and soft over a period of six to 12 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;

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

15) some tissue may slough (dissolve away) due to poor healing which may cause additional scars;

16) lumps, irregularities, depressions, or ridges may occur which can distort the skin of the brow and may be temporary or permanent;

17) frown lines and horizontal forehead lines may persist after this procedure;

18) occasionally, the brow lift cannot be accomplished only using the endoscope and it is necessary to make a traditional incision across the top of the forehead.

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 my 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 slough (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. 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. <u>Withholding medical and/or health information may result in further complications</u>.

10. 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.

Initials__________(person signing)

11. 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.

12. 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.

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

14. 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.

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

16 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