Lexington Plastic Surgery

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REQUEST FOR TREATMENT AND INFORMED CONSENT

FLAP AND GRAFT PROCEDURES

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 **DESCRIPTION OF THISPROCEDURE**is transfer of tissues from one facial or body area to another. This may include moving only a portion of skin, all layers of the skin, the underlying subcutaneous tissue, fascia, or muscle. Sometimes multiple layers are combined. These tissues may be left attached at one point (rotation flap) or may be entirely separated from the body and then put in the new location (grafts and free flaps).

2. The **DIAGNOSIS REQUIRING THIS PROCEDURE**is a wound or tissue defect. This may have resulted from trauma, surgery, removal of cancer, pressure ulceration, radiation, infection or other causes.

3. The **PURPOSE OF THIS PROCEDURE**is to obtain closure of the wound, restore an appropriate contour, seal a body cavity, and help eliminate infection or just provide healthy soft tissue to decrease the chance of a recurrent wound.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE**include doing nothing and accepting the circumstances ofmy medical condition. Wounds may continue, heal or worsen with time. The chance of cancer arising in a chronic wound increases with the amount of time it is left open.

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 allow progression of the medical condition and/or the possible need for more extensive surgery.

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 ANYLIMB 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) loss of the flap or graft or a portion of same. This may be related to infection, insufficient blood supply, excessive motion of the area, trauma to the tissue, fluid collection, smoking, cold exposure or other factors. All or portion of the flap or graft may have to be removed (debrided);

    2) failure to achieve complete healing of the wound. Even with successful graft or flap procedure, stable, lasting healing of a wound may not occur. This may be due to limitations of the flap or graft or the tissues in or surrounding the wound;

    3) the appearance of the treated area or the donor site may be unsatisfactory;

    4) the donor site from which the graft or flap is taken may not heal satisfactorily;

    5) a hematoma (blood collection) or seroma (fluid collection) may occur;

Initials _____ (person signing)

OTHER POSSIBLE RISKS (concluded)

6) infection may occur after surgery;

7) pain and discomfort may occur;

8) numbness (sensory loss, loss of feeling), or increased sensitivity may occur at or near any of the surgical sites;

9) tightness, firmness, areas of lumpiness and itching may occur which may be temporary or permanent;

10) scars will occur and may go from pink and firm to faded and soft over a period of 6 to 12 months; some scars may widen, become depressed, or appear raised, firm and "ropey" red which may take 2 years or longer to fade and soften; scars will be PERMANENT AND VISIBLE;

11) 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 scaring. **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 byme concerning my medical history and other information I provide in determining whether to perform the procedure or the course oftreatment 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.

10. I understand that the practice of medicine is not an exact science and that NOGUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE. There may be a need for additional surgery to treat the above complications, or for other reasons, which could include HOSPITALIZATION, TIME OFF WORK and additional EXPENSE to me or my insurance company.

11. 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.

12. 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.

13. 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