Lexington Plastic Surgery

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SUCTION ASSISTED LIPECTOMY (LIPOSUCTION) / ULTRASOUND

ASSISTED LIPOSUCTION / POWER ASSISTED LIPOSUCTION
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 excessive fatty tissue specifically located:

_____

2. The **NATURE OF THE PROCEDURE** is to attempt to remove some excess fatty tissue by a suction apparatus through small incisions just big enough to insert the suction tubes. If the ultrasonic technique is used, then the fat is liquefied with sound waves prior to suctioning it out through the tubes. Power assisted liposuction uses a motor to push the suction apparatus (cannula) back and forth in addition to the surgeon's motion.

3. The **PURPOSE OF THIS PROCEDURE** is to attempt to improve the contour of the area(s) specified by removal of some of the fat.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. Other practical alternatives include possible direct surgical removal by cutting and stitching. In certain areas, good physical condition and weight loss may help in some cases. There are various types of skin incisions that may be used.

5. **IF I CHOOSE NOT TO HAVE THE ABOVE NAMED PROCEDURE, MY PROGNOSIS (future medicalcondition)** 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** involve in this procedure including but not limited to:

    1) waviness, dimpling of the skin, contour irregularities and depressions in the skin may occur;

    2) body contour irregularities if due to tissue or structure other than fat (muscle, bone, intra-abdominal contents and/or glandular tissue) may persist:

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

Initials_____(person signing)

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

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

5) 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;

6) abscess formation (collection of pus) may occur;

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

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

9) loose skin may result;

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

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

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

13) pain and discomfort may occur;

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

15) scars will 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.

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

17) burns of the skin can occur with ultrasonic energy;

18) your level of physical activity may be decreased temporarily following surgery.

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 slough (dissolve 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 temporary 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. Withholding medical and/or health information may result in further complications.

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.

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 billed to insurance (this does not include cosmetic suction assisted lipectomy), 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 d 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