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Lexington Plastic Surgery™

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BLEPHAROPLASTY

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 blepharoptosis and blepharochalasis (apparent extra skin and/or fat around the eyes, perhaps with sagging or droopy skin and puffiness).

2. The **NATURE OF THE PROCEDURE** is to attempt to tighten the loose skin, taking away the extra skin surgically, and to remove bulging fat under the skin to reduce the puffy look. This is done by an operation called a blepharoplasty (an operation in which incisions are made in the upper lid crease and just below the lash line in the lower lid and each incision extends out past the eyes somewhat as needed).

3. The **PURPOSE OF THIS PROCEDURE** is to attempt to provide a more desirable contour and appearance about the eyes. Occasionally, the upper lid tissues hang out so far as to interfere with the visual field (line of sight), then the full field of vision may be improved.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. There are variations in the technique and anesthesia for blepharoplasty depending on my existing circumstances needs and wishes. My doctor will recommend the technique and anesthesia thought to obtain the best result and proper treatment in each case. Occasionally, chemical peels (painting the surface of the skin with a combination of ingredients) may be helpful for wrinkles or creases and smile lines. Cosmetics may also be considered.

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 preformed, 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) the cornea may be scratched and cause severe pain or permanent injury;

2) the eyes may become dry and irritated temporarily or permanently;

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7. OTHER POSSIBLE RISKS (concluded)

3) visual disturbances and blindness may occur;

4) the eyelids may not be symmetrical (perfectly balanced);

5) the surgery may not take out all of the creases or lines around the eyes caused by smiling;

6) there may be some residual excess skin or fat around the eyes;

7) there may be irritation of the cornea or conjunctiva (glassy eye covering over the middle and lining of the eye) which may require treatment;

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

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

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

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

12) skin deficiencies may occur which may require skin grafts;

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

14) pain and discomfort may occur;

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

16) 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;

17) some scars may be problematic and lead to drawing of upper lids up or cause ectropion (drawing the lower lid down); if this occurs, the patient may be unable to completely close the eyelids;

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 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. 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.

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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 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