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Lexington Plastic Surgery™

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THIGHPLASTY

REQUEST FOR TREATMENT AND INFORMED CONSENT

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

PATIENT: _____ DATE: ____/____/____

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

1. The **NATURE AND PURPOSE OF THIS PROCEDURE**, alternative methods of treatment, risks involved, and possible complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the procedure. I understand the procedure to be **BILATERAL MEDIAL THIGHPLASTY**

2. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is _____

3. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. Other alternatives may include: **DO NOTHING**

4. **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.

5. **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.

6. In addition to these material risks, there may be **OTHER POSSIBLE RISKS** involved in this procedure including, but not limited to: LOSS OF SENSATION TO SURGICAL SITE, HYPERTROPHIC SCARRING, NEED FOR REVISION, NEUROPATHIC PAIN, PROLONGED PAIN, VENOUS THROMBOSIS, FAT EMBOLISM, WOUND DEHISCENCE, DELAYED WOUND HEALING, ASYMMETRY, RE-LOOSENING OF SKIN OR SEROMAS.

7. 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 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.

8. 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.

9. 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. 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.

Initials _____

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10. 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.

11. I voluntarily consent to all 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.

12. 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