Advanced Cosmetic Surgery and Laser Center

Surgery Consent - page 1 (of 4)

Name _____

Name of Procedure:_____

Date of procedure: _____

To the Patient

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. The disclosure is not meant to scare or alarm you; it is simply an effort to better inform you to give or withhold your consent to the procedure.

Authorization must be signed by the patient if age 18 or over, or by a minor (under 18) if emancipated or by patent or legal guardian for any other minor, or by the patient's committee if the patient is incompetent.

I voluntarily request Dr. Mendelsohn and the staff of Advanced Cosmetic Surgery and Laser Center and such associates, technicians and other health care providers as they deem necessary, to carry out the following surgery (ies):

Advanced Lift

The Advanced Lift (Facelift) procedure has been explained to me by the above doctor and I completely understand the nature and consequences of the procedure.

The following points have been specifically made clear:

1. There are scars as a result of this surgery. Every effort will be made to conceal or to make them inconspicuous as possible.
2. There may be swelling in the face, which can persist for several weeks.
3. There may be bruising for several weeks, which can persist for several weeks. as well.
4. There may be scattered areas of numbness over the face and neck following the surgery, which may persist even for an indefinite period of time.
5. That no guarantee has been made as two the amount or percentage of improvement either in terms of the apparent age, or the permanency of the results.
6. That at times, following the surgery, fluid or blood may accumulate in the operative sites, which may require aspiration or drainage.
7. Although Dr. Mendelsohn has never had any permanent nerve injury, nerve damage can occur, which might cause a varying amount of facial paralysis.
8. That there may be discoloration for an indefinite period of time.

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Name _____

Date of procedure: _____

Blepharoplasty

The Blepharoplasty (eyelid) procedure has been explained to me by the above doctor and I completely understand the nature and consequences of the procedure.

The following points have been specifically made clear:

1. Incisions are used in and about the eyelids, and the incisions heal with scar tissue.
2. That there will be discoloration about the eyes for several days, and that in some cases, this can persist longer.
3. Due to the nature of the procedure, an exact end result cannot be predicted and I have not been given any guarantee of specific results.
4. That the incision lines usually are conspicuous early on post-operatively and for an indefinite period of time.
5. No assurance is given that the eyelids will be perfectly symmetrical.

Rhinoplasty

I realize the following additional risks and hazards may occur in connection with the following procedure:

1. Deformity of the skin, bone or cartilage
2. Perforation of the nasal septum
3. Breathing obstruction
4. Recurrence or worsening of the condition may occur
5. Additional surgery may be required for correction

Anesthesia

I understand that anesthesia involves additional risks and hazards but I request the use of anesthesia for the relief and protection from pain during the planned and additional (if indicated) procedures. I consent to the administration of anesthesia to be applied by or under the direction and supervision of the above named doctor or such anesthetists as they shall select, and to the use of such anesthetics as they may deem advisable, with the exception of: _____ (name of particular anesthetic). I realize the anesthesia may have to be changed, possibly without explanation to me.

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Surgery Consent - page 3 (of 4)

Name _____

Date of procedure: _____

I have been advised that part of this surgery is, or may be performed, through external incisions in the skin which will leave permanent scars, whose extent and location have been described and demonstrated to me. I have been advised that scars could take one year or more to mature; the changes that ordinarily occur in their appearance have been described to me. I realize that occasionally scars may have to be revised because of unsatisfactory appearance.

I understand that during the course of my operation, my doctor may discover other or different conditions which require additional or different procedures than those planned. I authorize him, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical procedure planned for me. I realize that additional risks occur, including the potential for infection, blood clots in the veins and lungs, hemorrhage, allergic reactions and even death. I also realize that the following risks and hazards may occur in connection with this procedure: unsatisfactory appearance, poor healing, skin loss, nerve damage, painful or unattractive scarring, impairment of organs, such as eye or lip function.

I consent to the administration of anesthetics to be applied by or under the direction of the doctor and to the use of such anesthetics and medications, as he may deem advisable in my case.

Smokers are recognized to have a significantly higher risk of post-operative would healing problems, as well as operative and post-operative bleeding. Patients should discontinue smoking for four (4) weeks before and after surgery. Although is helps to stop smoking for several weeks before and after surgery, this does not eliminated the increased risk resulting from long-term smoking.

_____ If initialed, I have been told a medical-grade synthetic implant may be used in the above mentioned operation and have been advised of the risks as well as alternative methods of treatment. I understand that on occasion, implants are rejected by the body.

_____ If initialed, I have been informed that the above operation my require transplantation from other areas of my body or from other persons (Rhinoplasty).

I certify that I have read the literature provided and filled out the patient registration and medical history form fully and correctly, to the best of my knowledge, and that the information I have supplied is complete and correct.

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Surgery Consent - page 4 (of 4)

Name _____

I agree to follow the instructions given to me by my doctor and his staff to the best of my ability before, during and after the above mentioned surgical procedure, and will notify my doctor of any problems following my surgery.

To my knowledge, I am not allergic to anything except: _____

I certify that my doctor has discussed the operation with me to my satisfaction; that this form has been fully explained to me; that I have read it or had it read to me; that the blank spaces have been filled in and that I understand its content.

I hereby give permission for the observation of this procedure by students for educational purposes.

I understand that no warranty or guarantee has been made to me as the result or cure.

I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be sued and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I hereby give permission to my doctor or any assistant he may designate to take photographs for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain in his property.

I further ___ **authorize him** ___ **do not authorize him** to use such photographs for teaching purposes or to illustrate scientific papers, books or lectures if, in his professional judgment, medical research, education or science will be benefited by their use. This consent will remain in effect until revoked by me in writing.

In the event of a life-threatening incident, cardiac or respiratory arrest, the policy of the Advanced Cosmetic Surgery and Laser Center is to aggressively treat, resuscitate, stabilize and transfer all patients. The Advanced Cosmetic Surgery and Laser Center will not honor Advanced Directives, Do Not Resuscitate Orders and Living Wills. Any patient who does not wish resuscitation to be performed will not be treated at ASLC.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

_____

Signature Date

_____

Witness Time