

INFORMED CONSENT AND REQUEST FOR COSMETIC SURGERY (FAT GRAFTING)

You have the right as a patient, to be informed about your condition and the intended surgical procedure, so you may make the decision whether to undergo the procedure after knowing the general risks involved. This disclosure is not meant to scare or alarm you. This is simply an effort to make you better informed so you may give or withhold your consent for the procedure.

I voluntarily request that my physician, and such associates, technical assistants and other health care providers as they deem appropriate, treat my condition which has been explained to me be: **FACIAL AGING.**

I understand that the following surgical procedure is planned for me, and I voluntarily consent, request and authorize this procedure: **FAT GRAFTING.**

I understand that my physician may discover other or different conditions which may require additional or different procedures than those planned. I therefore authorize my physician and such associates, technical assistants and other healthcare providers as he may deem appropriate to perform such other procedures at the time of surgery, as they deem advisable in their professional judgment.

I have been advised that the object of the procedure I have requested is an elective change in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science, and that any reputable physician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warrantee or assurance has been made to me by my physician or anyone regarding the outcome of the procedure(s) which I have requested and authorized. I also understand the limitations of this procedure.

I have been advised that this procedure may be performed through external incisions in the skin which leave permanent scars, whose extent and location have been described to me. I have been advised that scars take upwards of one year to mature, and the changes that normally occur in their appearance during the healing period have been described to me. The intended locations and extent of scars have also been indicated to me.

I understand there are risks inherent in any treatment, procedure or surgery. The potential always exists for infection, hemorrhage, bleeding, bruising, swelling, discomfort, blood clots in veins or lungs, allergic reaction, and even death. I also realize that the following risks and hazards may occur in connection with this particular procedure:

FAT GRAFTING

These problems could also necessitate further procedures which may or may not correct them. I realize the specifically identified risks are those that are most inherent in the procedure or surgery authorized and that the list of remotely possible material risks is nearly unlimited.

I also understand that certain complications may result from the use of any anesthetic (local or general) agents including cardiac or respiratory problems, drug interaction, paralysis, brain damage and even death. Other risks and hazards which may result from the use of general anesthesia range from discomfort to injury to the vocal cords, teeth and eyes. I also 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 procedures. I also understand there is a possibility the anesthesia may be charged without explanation to me.

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(FAT GRAFTING) - CONTINUED**

I hereby give permission to my physician or any assistant he may deem appropriate to photograph the intended surgical site for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain my physician's property. I further authorize my physician to use these photographs for teaching purposes, to illustrate scientific papers, books, or for use in general lectures. It is specifically understood that I shall not be identified by name in any such publication or use.

THIS PART IS TO FEMALE PATIENTS ONLY. Anesthetic agents or any other medications can be harmful to the fetus of a pregnant woman. General anesthesia should be avoided during pregnancy whenever possible. I hereby state that I am not pregnant and accept responsibility of making this determination before procedure or surgery hereby authorized.

THIS PARAGRAPH PERTAINS TO SMOKERS. Smokers are recognized to have a significantly higher risk of post-operative wound healing problems and complications, as well as operative and post-operative bleeding. Patients should discontinue smoking for several weeks before and after surgery. Although it helps to stop smoking for several weeks before and after surgery, this does not eliminate the increased risk resulting from long-term smoking.

I am aware that I will be given pre-operative narcotic and sedative medications and that the effects of these drugs will not subside by the time I am discharged. Some drowsiness may continue throughout the remainder of the day following surgery. Operation of a motor vehicle is not advised for 24 hours after any drug administered, nor should any important decisions be made. I understand that because of the potential effects narcotics may have, it is recommended that a legal responsible adult drive me home and stay with me for at least 24 hours after my procedure or surgery (or longer if I remain sedated etc.).

I agree to follow the instructions given to me by my physician to the best of my ability before, during, and after the surgical procedure. I understand that patient responsibility and proper performance of the post operative care and regular office visits are critical to the success of the operation. I have thoroughly read and understand the post-operative instruction and reviewed them with my physician's staff. I acknowledge that I have read and filled out the patients' registration and medical history form fully and correctly to the best of my knowledge, and that the information I have supplied is correct.

My physician has fully explained in terms clear to me the nature of the procedure to be performed, the foreseeable or common risks and complications, alternative methods of treatment, as well as what I may experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask any questions I desire regarding the diagnosis and surgical procedure and that these questions have been fully explained to me in layman's terms. I have read this document (or have had it read to me) and I understand its contents. I hereby give my unrestricted informed consent for the surgical procedure.

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

Patient / Legal Guardian

Date

Physician

Date