

## INFORMED CONSENT FOR SURGERY

Name \_\_\_\_\_ Date \_\_\_\_\_

Initial

- \_\_\_\_\_ 1. I hereby request and authorize David A. Hendrick, M.D., his assistants, and operating room personnel to perform the following operation or procedure(s) \_\_\_\_\_  
\_\_\_\_\_ to be performed on or about \_\_\_\_\_. In general, the purpose of the operation or procedure(s) is: \_\_\_\_\_.
- \_\_\_\_\_ 2. In the event of unforeseen circumstances encountered during my procedure(s), I also hereby authorize Dr. Hendrick to perform any other procedure(s) or take whatever measures that he may deem necessary or desirable in addition to or in substitution for the procedure(s) initially contemplated.
- \_\_\_\_\_ 3. I consent to the administration of such anesthetics by medical staff as may be considered necessary or advisable by the physician or provider responsible for this service. In the event an anesthesiologist is used for my procedure, they are providers who are not under the employment of Heartland Cosmetic and Reconstructive Surgery. I understand that anesthesia or sedation involves additional risks and hazards, but I request the use of anesthetics or sedation for the relief and protection from pain during the planned and additional procedures. I realize the anesthesia or sedation may have to be changed, possibly without explanation to me. I understand that certain complications may result from the use of anesthetics or sedatives including respiratory problems, drug reaction, paralysis, brain damage, or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to the vocal cords, teeth or eyes.
- \_\_\_\_\_ 4. THIS PARAGRAPH IS FOR FEMALE PATIENTS ONLY. Anesthetic agents 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 the responsibility of making this determination.
- \_\_\_\_\_ 5. The effect, nature and purpose of the operation or procedure(s), possible alternative methods of treatment, the foreseeable risks involved, and the possibility of complications have been fully explained to my satisfaction, in terms clear to me, by Dr. Hendrick.

- \_\_\_\_\_ 6. I certify that I have received copies of and have read or had read to me and understood the medical literature pertinent to the proposed surgery given to me by Dr. Hendrick, including:
- \_\_\_\_\_ Information About Surgical Risks
  - \_\_\_\_\_ Specific Surgical risks for \_\_\_\_\_
  - \_\_\_\_\_ Preoperative Instructions
  - \_\_\_\_\_ Postoperative Instructions for \_\_\_\_\_
  - \_\_\_\_\_ Information Sheet for \_\_\_\_\_
  - \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ 7. I understand that a medical grade implant and/or the transplant of tissue, cartilage, or bone from other areas of my body will / will not be considered for use in the above-named procedure(s). In the event that an implant or transplant in the form of \_\_\_\_\_ is being considered as part of my procedure(s), the possible risks as well as the alternative methods of treatment have been explained to me. I understand that on occasion, implants are rejected by the body.
- \_\_\_\_\_ 8. I have been made aware that any surgical operation involves general risks, including but not limited to those discussed in the information packet given to me.
- \_\_\_\_\_ 9. I understand that the practice of medicine and surgery is not an exact science and that, therefore, a physician cannot guarantee results. In this connection, I accept that there is a possibility that imperfections might ensue from the operation or procedure(s) and that the results might not live up to my expectations or the desired goals that have been established. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation or procedure(s) which I have herein requested and authorized.
- \_\_\_\_\_ 10. I understand that treatment of any unusual or serious complications requiring admission to a hospital is not covered by the cost or charges quoted in connection with this surgery. In addition, I have been made aware that such complications could require the service of additional physicians and none of these fees or charges are included.
- \_\_\_\_\_ 11. I realize that as in all medical treatment, complications or delay in recovery may occur which could lead to the need for additional treatment or surgery and could also result in economic loss to me because of my inability to return to normal activity as soon as anticipated.
- \_\_\_\_\_ 12. It is understood that the two sides of our bodies are different and asymmetrical and this includes the face, eyes, chest, breasts, nipples, and all other parts of our bodies. While we usually want to make our two sides more alike, it is understood that it is not possible to make them alike. The two sides of our bodies will always be different, unequal and asymmetrical in every way to some degree. I understand that residual asymmetry between the two sides of the body operated on can be expected and is generally considered acceptable.
- \_\_\_\_\_ 13. I have been advised that any incisions made in the skin will leave permanent scars. The extent and location of these planned incisions have been described to me. I have also been advised that scars take up to one year to mature and the changes that normally occur in their appearance during the healing period have been described to me. I understand that healing abilities vary from person to person and that my individual tendency to form scar tissue cannot be accurately predicted prior to surgery. I realize that occasionally scars may have to be revised because of unsatisfactory appearance. I also realize that I may be responsible for any fees associated with revision or treatment of scars.

- \_\_\_ 14. I understand that swelling, bruising, and discoloration is a natural consequence of surgery. Such swelling, bruising, and discoloration normally disappears within a few days to weeks but may require several weeks or even months to completely disappear in some individuals.
- \_\_\_ 15. I understand that there are risks and hazards related to the surgical procedures planned for me. I realize that any surgical procedure has 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 and prolonged pain and discomfort, painful or unattractive scarring, and impairment of organs such as eye or lip function, when surgery is performed in those areas. Hair loss can occur when incisions are made in the scalp, and although usually temporary can be permanent.
- \_\_\_ 16. THIS PARAGRAPH PERTAINS TO SMOKERS. Smokers are recognized to have higher risks of postoperative wound healing problems as well as operative and postoperative bleeding. Patients should discontinue smoking for two weeks after surgery. Although it helps to stop smoking for several weeks before surgery, this does not eliminate the increased risks of long-term smoking.
- \_\_\_ 17. I hereby give permission to Dr. Hendrick or any assistant he may designate to take any photographs during the course of the procedure(s) which he deems necessary to enhance the medical record. I agree that these photographs will remain his property. I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures if, in his judgment, medical research, education, or science will benefit by their use. It is specifically understood that in any such publication or use I shall not be identified by name.
- \_\_\_ 18. I understand that if Dr. Hendrick judges at any time that my surgery should be canceled for any reason, he may do so.
- \_\_\_ 19. I have been advised that postoperative depression is common after any form of cosmetic surgery. Such depression is usually related to the immediate postoperative discomfort, anxiety over distorted appearance (swelling and bruising), and limitation of activities and socializing. I understand that as appearance improves and as I return to my usual activities and interests, these feelings should disappear.
- \_\_\_ 20. I understand that touch-up procedures are occasionally needed in cosmetic or aesthetic surgery. If Dr. Hendrick determines that such procedures are needed, I may or may not be charged a fee for the surgeon's services. Regardless, fees for anesthesia, supplies, and the operating room will usually be required and charged.
- \_\_\_ 21. I authorize Dr. Hendrick to retain, preserve and use for scientific or therapeutic purposes or to dispose of, in accordance with the customary practice, any specimen or tissue taken from my body during this operation or procedure. In the event any tissue is deemed potentially pathological it will be sent to pathology and I will be responsible for a separate pathology bill.
- \_\_\_ 22. I agree to follow the instructions given to me by Dr. Hendrick, either written or verbal, to the best of my ability before, during, and after the above-named procedure(s) and that I will, as soon as possible, notify him of any questionable or potentially unhealthy conditions that may arise.

\_\_\_23. I certify that I have read and filled out the patient registration and medical history form fully and correctly to the best of my knowledge. I hereby state that the written information I furnished Dr. Hendrick during my initial consultation and/or preoperative evaluation is complete and correct and that I have disclosed all my known medical conditions, allergies, or adverse reactions to medical preparations. I understand that withholding medical information could lead to complications or problems that may have been prevented if that information were known prior to surgery.

\_\_\_24. I understand that other physicians might recommend a different procedure and that I am free to seek the advice of any physician or physicians I might choose. Prior to signing this document, I have taken the time to consider whether or not I wish to ask any further questions of Dr. Hendrick or whether I desire to obtain a second opinion from another physician. I understand that by signing this document I voluntarily and of my own free choice elect to undergo the operation or procedure listed above.

\_\_\_25. I certify that all blanks requiring insertion or completion have been filled in prior to my signing this form and that I have read and fully understand this informed consent for surgery. I further acknowledge that I have been given an opportunity to ask any questions I desired and that these questions have been answered to my complete satisfaction. I completely understand the nature and consequences of the procedure and hereby wish to proceed with the surgery.

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

Signed \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

Signed \_\_\_\_\_ Relationship \_\_\_\_\_  
(Person authorized to give consent if patient is a minor)

Witnessed: \_\_\_\_\_  
(Not a member of the family)