

Fairfield County Plastic Surgery

INFORMED CONSENT FOR FACIAL IMPLANTS

Patient's Name:

All surgery has risks and complications. No procedure is risk free. The risks are small but do exist. Complications are kept to a minimum by making sure that you are well prepared for surgery, both physically and mentally. All medical conditions such as epilepsy, hyperthyroidism, kidney disease, high blood pressure and diabetes must be under control. If you have a medical condition of which we are unaware it is your responsibility to let us know. In general, if you have an acute illness such as the flu, a bad cold or an infected pimple, it is safer to cancel the surgery and reschedule when you are in the most optimal condition. If you develop an acute illness which may require cancellation of surgery please let us know immediately. Sometimes medication may cure the problem and avoid cancellation. **Smoking increases the risk of bleeding during and after surgery and should be avoided for three weeks before and after surgery.** Smoking impairs wound healing and causes tissue necrosis. Blood thinners such as aspirin and Advil must be avoided for at least three weeks before surgery. Please review the list of blood thinning medications we have given you.

GENERAL:

Surgery you do not need—Purely elective surgery

Realistic expectations—key to success

CHANGES

Unavoidable: Deterioration/Aging, Gravity, Ethnic group/familial tendency

Avoidable: Sun, Expressiveness

WHY HAVE THIS OPERATION?

Self, Not for Others, Repair/Maintenance,

WHAT WILL USUALLY BE HELPED?

Contour only

WHAT WILL NOT BE HELPED?

Skin quality , muscle, fat collections

GOALS:

Make you look as good as we can

LIMITATIONS:

Cannot recreate young skin

Cannot prevent aging

Cannot alter developmental asymmetries

Cannot solve personal problems

GOALS MAY ONLY BE PARTIALLY MET

HOW LONG WILL IT LAST?

Usually the result is permanent. Tissue over the implant may change with ageing requiring revision of the implant

ALTERNATIVES:

Leave everything as it is (adverse consequences?)

Collagen, fat injection

SURGICAL TECHNIQUE / ANESTHESIA /FACILITY / RECOVERY

Local anesthesia & sedation vs general anesthesia

Office OR / Hospital OR

Incisions

Dressings

Post-op hospitalization

Return to normal activities

TRADE-OFFS:

Temporary:

*Discoloration/swelling, bruising for about two weeks

*Discomfort (pain /sensitivity)

*Tightness/ relaxation

*Asymmetry

*Lumps/ irregularities

*Restricted activity

Permanent:

*Scars

submental scar for chin implant

RISKS/ COMPLICATIONS:

• hematoma necessitating removal of sutures (more common in smokers and patients with high blood pressure). may require removal of implant

• infection (rare) - but may require removal of implant

• asymmetry, note that asymmetry of the face is normal. The asymmetry will not always be corrected by surgery.

• Loss of feeling in upper lip or lower lip, usually temporary

• Nerve weakness or injury to upper or lower lip or forehead. Weakness is usually temporary and due to stretching of nerves and recovers spontaneously. Weakness may last for several weeks.

• implant exposure (rare)

• assymetry or malposition may require removal or repositioning of implant

• Reaction to medications

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Facial Implants

Even though the risks and complications cited above occur infrequently, they are the ones that are peculiar to the operation or of greatest concern—other complications and risks can occur but are even more uncommon. The risks of surgery are comparable to the risks you take everyday when driving or riding in an automobile.

Any and all of the risks and complications can result in:

Additional surgery / Time off work

Hospitalization / Expense to you

Insurance usually DOES NOT cover this procedure; treatment of complications may or may not be covered by insurance. On occasion, surgical revision may be indicated following the original surgery. If planned or performed within one (1) year after the original surgery and if insurance does not cover these revisions, there will be no charge by the surgeon but a facility fee will be charged by the hospital for use of the operating or treatment room and an anesthesia fee will be charged by the anesthetist.

NO GUARANTEE—The practice of medicine and surgery is not an exact science; although good results are expected, there cannot be any guarantee, nor warranty, expressed or implied, by anyone as to the results that may be obtained.

COMMENTS:

****If a smoker—must be off cigarettes for three (3) weeks before surgery and remain off cigarettes for three (3) weeks after surgery; much greater risk for scarring, poor healing, hair loss, skin loss in smokers.**

*****Must be off all aspirin containing products and Vitamin E for three (3) weeks before surgery and three (3) weeks after surgery. (Check all medications with us; some medications such as Motrin and Advil may also affect clotting.)**

If there is any item on this consult sheet that you do not understand, mark it and call the office. An explanation or additional information will be provided. Share the information we provide you with your husband or other interested family members or friends. I will be happy to meet with them if you wish.

I have read this form and had the opportunity to discuss any related questions with.

Date: _____ Patient: _____

Date: _____ Surgeon: _____

Copied and provided to patient by: _____ A copy of this consultation was provided to

me: _____ (Patient's signature)

NOTHING BY MOUTH AFTER MIDNIGHT / RELEASE FROM RESPONSIBILITY and PEER REVIEW

Date: _____ Time: _____

_____ (name of patient or myself) has not had anything to eat or drink, including water, since midnight, in preparation for surgery scheduled today. (Pre-operative medications can be taken with a sip of water). I authorize Dr. Kirwan or Dr. Roen to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until date of conclusion of such treatment, to those individuals who in Dr. Kirwan's or Dr. Rosen's sole determination, are required to receive such information for the purposes of *medical treatment, medical quality assurance and peer review*.

Patient Parent Or Guardian If Applicable

Witness: _____ Signature: _____