

**CONSENT FOR SURGICAL AND SUCTION ASSISTED LIPECTOMY (FAT REDUCTION)**

**Patient's Name:** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE CHECK EACH BOX AFTER READING. If you have any questions please ask your doctor.**

- I authorize Dr. Reynolds/Dr. Auble to perform the following procedure(s): \_\_\_\_\_  
\_\_\_\_\_
- These procedures are necessary to treat the following condition(s): \_\_\_\_\_  
\_\_\_\_\_
- The possible alternate methods of treatment (if any), include, \_\_\_\_\_  
\_\_\_\_\_
- Suction-assisted lipectomy is the surgical technique used to remove localized collection of fat beneath the skin. It is sometimes combined with direct surgical lipectomy in selected cases. I understand that the purpose of my surgery is to attempt to improve the appearance of localized areas on my body.
- I have been completely candid and honest with my doctor regarding my motivation for undergoing liposuction, realizing that a new appearance does not guarantee an improved life.
- I realize the importance of providing true and accurate information about my health, especially concerning possible pregnancy, allergies, medications and history of drug or alcohol use. If I misinform my doctor I understand the consequences may be life-threatening or otherwise adversely affect the results of my surgery. I have discussed my past medical history with the doctor and have disclosed ALL diseases and medications, including alcohol and drug use past and present.
- It has been explained to me that suction-assisted lipectomy is a surgical technique suitable for selected patients. It is not a substitute for weight reduction that can ordinarily be obtained by dieting and exercise, and it is not a cure for obesity.
- It has also been explained to me that my physical condition may require surgical lipectomy in which excess skin and fat may be removed instead of, or in addition to, suction-assisted lipectomy.

**SURGICAL CONSIDERATIONS**

- The technique of liposuction has been explained to me. I understand that it may be performed under local anesthesia or in conjunction with the use of intravenous sedation or a general anesthetic. Small skin incisions are made in selected locations, through which a blunt, tubular instrument (catheter) is inserted to suction fat deposits from beneath the skin. I have been advised that additional or larger incisions may be necessary to gain adequate access to all areas of unwanted fat.
- Recognizing that during the surgery some unforeseen condition may be discovered that may necessitate a change in approach or different procedure from those explained above, I authorize Dr. Reynolds/Dr. Auble to perform such procedures as are necessary and advisable in the exercise of his professional judgment.

**POST-OPERATIVE CONSIDERATIONS**

- All incisions will be closed with small sutures, however, slight scarring may be expected. I have been advised that in some patients, scarring is unpredictable and may be more noticeable. If necessary, a secondary procedure may be performed to attempt to minimize scarring.
- After surgery a snug dressing of elastic gauze will be applied to the surgical areas to help conform the skin to the shape of the underlying tissues. This pressure bandage will be in place for about two weeks. Some bruising and swelling may persist for several weeks after surgery. Some post-operative discomfort can be expected and medications will be prescribed to provide adequate relief.
- I have been advised and understand that patients react differently to liposuction, depending upon age and health. Some individuals have different skin elasticity and may require additional procedures to remove or tighten excess skin. Further, some patients' skin may tend to wrinkle more than others.
- I will avoid strenuous physical activity, exercise, etc., for at least two weeks after surgery.

**RISKS AND COMPLICATIONS**

# REYNOLDS ORAL & FACIAL SURGERY



- I understand that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risks include, but are not limited to:
- The possibility of a second surgery/procedure in the event an abundance of excess fat is encountered.
- Ordinarily, liposuction of the face and neck does not cause excess bleeding that would require blood transfusion. Nevertheless, there is the remote possibility of blood transfusion and I understand I may donate my own blood before surgery so that it may be transfused back to me if necessary.
- I understand that this surgery involves the risk of numbness of the skin overlying the area of fat removal. In most cases, this condition is temporary, but in rare cases may be permanent.
- It is possible that after fat removal the overlying skin will not be smooth, but may appear to have a “wash-board” appearance. A second liposuction or other cosmetic procedure may be necessary to attempt correction of this condition.
- In the event fat is to be removed from the cheek area, I have been advised that there is a possibility of injury to the nerves that control the muscles of facial expression, causing a loss of facial tone and decreased function. This condition is usually temporary, but may be permanent.
- Any surgery involves the risk of infection that may require antibiotic treatment. Most infections resolve without complication, but, in rare instances, treatment may involve hospitalization and may affect the planned outcome of the surgery.
- There is a possibility of localized collection of blood (hematoma) in the areas of fat removal. Secondary surgical procedures may be necessary to drain those areas.

## ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

- I understand smoking is extremely detrimental to the healing process. **I agree to cease all use of tobacco for 6 weeks prior to and 6 months after surgery and to make strong efforts to give up smoking entirely.**
- Recognizing that during the surgery some unforeseen condition may be discovered that may necessitate a change in approach or different procedure from those explained above, I authorize Dr. Reynolds/Dr. Auble to perform such procedures as are necessary and advisable in the exercise of his professional judgment.
- No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that the treatment would be helpful, and I have weighed the risk with the proposed benefits.
- I have discussed my past medical history with the doctor and have disclosed ALL diseases and medications, including alcohol and drug use past and present.
- I agree to cooperate completely with the recommendations of Dr. Reynolds/Dr. Auble, realizing that lack of cooperation may result in a less than optimal result.
- I have reviewed / viewed pre-operative and post-operative instructions.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in, and any inapplicable paragraphs were stricken before I signed. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

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Patient's (or Legal Guardian's) Signature

Date

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Doctor's Signature

Date

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Witness' Signature

Date