REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR SCAR REVISION

Patient's Name:_____ **Date**_____

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

- ❑ I understand that and I understand the benefits and risks of such surgery. This is NOT minor surgery and I have been fully informed about my condition and the recommended treatment options.
- ❑ I authorize Dr. Reynolds/Dr. Auble to perform the following procedure(s):Scar revision (including excision of existing scar and re-closure of the wound); dermabrasion; laser resurfacing; re-directing the scar to make it less visible, which may include Z-plasty or W-plasty)
- ❑ These procedures are necessary to treat the following condition(s): Widen scar, hypertrophic scar, hypotrophic scar, excessively visible scar
- ❑ The possible alternate methods of treatment (if any), include: Non-invasive laser treatments
- ❑ 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:
  - ❑ Post-operative swelling, discomfort, bruising, bleeding, hematoma (blood clot), wound infection, and limitation of function, any of which may require further care.
  - ❑ Adverse or allergic reactions to medications or anesthesia causing multiple side effects, some of which may be serious and require additional care or hospitalization.
  - ❑ Reaction to foreign material which may have been introduced into the wound by the trauma, or "tattooing" of the skin or mucosa from particles of foreign material from the original trauma.
  - ❑ Worsening of scarring because of aberrations in healing such as keloid formation.
  - ❑ Facial muscle weakness; particularly of the lower lip, if the scar is near the lower border of the jaw bone; the eyelid, if the scar is near the temporal region; or other muscles of facial expression caused by injury to motor nerves in the area. Such weakness may be partial or total and may be temporary or permanent.
  - ❑ Sensory nerve injury causing pain, numbness, or other sensory alterations anywhere in the area of the procedure, which may temporary of permanent.
  - ❑ Other:_____
- ❑ I understand that additional injury may be discovered during treatment that might necessitate a change in approach or a different procedure from those explained above and I authorize my doctor to perform such procedures that are necessary and advisable in the exercise of professional judgment.
- ❑ I understand that this is complex treatment and there can be no guarantee of complete resolution of my present symptoms. Occasionally there may be an increase in the scar size or symptoms or noticeability of the scar. I also understand that additional treatment may be necessary post-operatively, including (but not restricted to) re-treatment by scar revision, dermabrasion, laser resurfacing, non-invasive laser treatment, physical therapy, dermal filler (such as fat injections), etc.
- ❑ I have been told of my option for a second opinion regarding the proposed treatment from another qualified professional.

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.

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- ❑ 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 re-treatment, 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 understand that hygiene will be difficult following surgery, but will do my utmost to follow hygiene routines and follow the directions for wound care as directed by Dr. Reynolds/Dr. Auble.

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.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date