PLASTIC SURGERY CENTER OF ST. JOSEPH, INC.
MICHAEL D. DE PRIEST, M.D.

CONSENT FOR BLEPHAROPLASTY

PATIENT:_____

DATE OF SURGERY:_____

1. I authorize Dr. Michael De Priest to perform an operation for improving the appearance of aging eyelids known as blepharoplasty.

2. Dr. De Priest has explained the procedure to me, and I understand the nature and consequences of the procedure.

3. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that there are no guarantees as to the results of the operation, permanency of the results, or my satisfaction with the results.

4. The following are expected results after Blepharoplasty:

   a. Permanent scars where incisions have been made.
   b. Lack of perfect eyelid symmetry since right and left eye anatomy is rarely identical.
   c. Continuing of the aging process such that new sagging and wrinkles may develop over the ensuing years.
   d. Transient discoloration and swelling.

5. I know that every surgical procedure involves certain risks and the possibility of complications such as bleeding, infections, poor wound healing, etc. I know that certain complications may follow blepharoplasty surgery--even when the surgeon uses the utmost care, judgment and skill. The list below contains several (but not all possible) complications that can follow blepharoplasty. The doctor and nurses have discussed these points to my satisfaction, and I accept the risk of their occurrence.

   a. Blindness
   b. Sagging of the lower eyelids such that the eye does not completely close. This might require a second operation to ensure continued good vision.
   c. Loss of eyelid skin resulting in wide scars or necessitating a skin graft.
   d. Excessive bleeding or infection which may necessitate hospitalization or a second surgery.

6. I recognize that during the course of the operation, unforeseen conditions may necessitate additional and/or different procedure than those explained. I further authorize and request that the surgeon perform such procedures as are, in his professional judgment, necessary and desirable. The authority granted under this paragraph shall allow the doctor to treat conditions that the doctor may not know of or that he does not anticipate when the operation begins. This may include transfer and admission to a hospital.

7. I consent to the administration of local anesthesia and intravenous anesthetic agents by or under the direction of the surgeon. I accept this risk and agree to discuss any questions I have concerning anesthesia with Dr. De Priest prior to surgery.

8. I consent to photographs before, during and after the treatment. These photographs shall be the property of Dr. De Priest.

9. I agree to keep Dr. De Priest informed of any change in address, and I agree to cooperate with him in my care after surgery until completely discharged.

10. I have read the above consent and received a copy of it. I understand the contents, and have had the opportunity to ask questions concerning it. I hereby request and authorize Dr. De Priest to perform a blepharoplasty on me. I have also received and studied the informational brochure on this procedure.

11. I further authorize and consent to the disposal of any tissue removed.

12. I also consent to being transferred to a hospital for treatment if necessary.

13. This permit also includes a release to draw blood if the physician or an assistant is accidentally stuck with a needle contaminated by my blood or body fluids.

PATIENT:_____ **DATE:**_____

WITNESS:_____

M.D. SIGNATURE:_____

Phyllis Mulder, RN, CPSN
Brenda Boller, RN
Tony Claycomb, RN
Pat Higdon, RN
Terry Hurst, RN