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

CONSENT FOR REDUCTION MAMMOPLASTY

PATIENT:_____

DATE of SURGERY:_____

1. I authorized Dr. Michael De Priest to perform a surgical procedure for reducing breast size known as reduction mammoplasty.

2. Dr. De Priest has explained the breast reduction operation, and I completely understand the nature and consequences of the procedure.

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

4. The following are expected results after reduction mammoplasty:

    a. Permanent scars where incisions have been made
    b. Area of numbness and tightness. These usually resolve over several weeks, but may be permanent.
    c. Lack of total breast symmetry, particularly in the patient whose two breasts prior to operation were of different shape.
    d. Transient swelling and skin discoloration.

5. It has been explained to me that every surgical procedure involves certain risks and possibilities of complications, such as bleeding, infection, poor wound healing, etc. Certain complications are known to follow breast reduction 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 a reduction mammoplasty. These points have been discussed to my satisfaction, and I accept the risk of their occurrence.

    a. Excessive bleeding, infection or wound separation which may necessitate hospitalization or a second operation.
    b. Possible nipple loss; inability to breast feed
    c. Delayed wound healing; keloid formation (heavy scarring, particularly in patients prone to scar formation)

6. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures that those explained. I, therefore, further authorize and request that Dr. De Priest perform such procedures as are, in his professional judgment, necessary and desirable. The authority granted under this paragraph shall extend to remedy conditions that are not know to, or could not reasonably be anticipated by Dr. De Priest at the beginning of the operation.

7. I consent to the administration of local anesthesia agents by or under the direction of Dr. De Priest. I consent to the administration of general anesthetic agents by trained personnel working with Dr. De Priest. I understand that the use of general anesthesia presents additional risks over which Dr. De Priest has no control. I accept this risk and agree to discuss any questions I have concerning anesthesia with the anesthesia personnel prior to surgery.

8. I consent to be photographed before, during and after the treatment; these photographs shall be the property of Dr. De Priest and will be kept confidential.

9. I agree to keep Dr. De Priest informed of any changes 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 request and authorize Dr. De Priest to perform a reduction mammoplasty on me. I have also received and studies the information booklet on this procedure.

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:_____