

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

CONSENT FOR RHYTIDECTOMY

PATIENT: \_\_\_\_\_

DATE of SURGERY: \_\_\_\_\_

1. I authorize Dr. Michael De Priest to perform a surgical procedure for tightening facial skin known as rhytidectomy (facelift).
2. Dr. De Priest and his nursing staff have explained the rhytidectomy procedure. 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, and 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 Rhytidectomy:
  - a. Permanent scars where incisions have been made.
  - b. Areas of numbness and tightness. These may resolve over several weeks, but they may be permanent.
  - c. Continuing of the aging process such that new sagging and wrinkles may develop over the ensuing years.
  - d. A small recession or "step-off" in the hairline. There is occasional hair loss near the incisions.
  - e. Transient facial swelling, and discoloration.
5. The doctor and his nursing staff explained to me that every surgical procedure involves certain risks and possibilities of complications such as bleeding, infection, poor wound healing, etc. I know that complications can follow facelift 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 rhytidectomy. We have discussed these points to my satisfaction, and I accept the risk of their occurrence.
  - a. Facial nerve damage such that there is temporary or permanent facial weakness or paralysis.
  - b. Loss of facial skin resulting in wide scars or necessitating a skin graft.
  - c. Excessive bleeding or infection which may necessitate hospitalization or a second operation.

- d. Possible need for revision surgery, especially in the event of complications.
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 Dr. De Priest perform such procedures as are, in his professional judgment, necessary and desirable. The authority granted under this paragraph extends to remedy conditions that are not known to (or could not be anticipated by) Dr. De Priest at the time the operation begins. This may include transfer and admission to a hospital.
7. I consent to the administration of local anesthetic agents and intravenous sedation by the surgeon. If I need general anesthesia, trained and licensed anesthesia personnel will give the medications. I understand that the use of a general anesthetic 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 photographs before, during and after the operation. These photographs are confidential and are the property of Dr. De Priest.
9. I agree to keep Dr. De Priest informed of any change in address or telephone number, and I agree to cooperate with him in my care after surgery until I am discharged.
10. I have read this consent and received a copy of it. I understand the contents, and I have had the opportunity to ask questions concerning it. I request and authorize Dr. De Priest to perform a rhytidectomy on me. I have also received and studied the informational brochure on this procedure.

**PATIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_

**M.D. SIGNATURE:** \_\_\_\_\_