Merheb Surgical Arts

CONSENT FOR FACE-LIFT SURGERY (RHYTIDECTOMY) AND ENDOSCOPIC BROWLIFT/MIDFACELFT, NECK LIFT._____

_____

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

I have been informed that I have the following condition(s):

_____

_____

_____

The procedure(s) to treat my condition(s) has/have been described as:

_____

_____

_____

___1. A brow lift/ Midaface lift/ Neck lift/ Facelift is an aesthetic surgery to attempt to minimize or reduce evidence of aging, such as wrinkles and sagging of the skin forehead, brow complex, cheek area and neck. Although this surgery will provide a person with more youthful appearance, it is impossible to predict the exact result of surgery. The degree of improvement is a subjective opinion and will be partly determined by age, heredity, bone structure and various individual characteristics of the skin as well as personal habits such as smoking, alcohol intake and nutrition.

___2. I have been completely candid and honest with my doctor regarding my motivation for undergoing Aesthetic surgery, and realize that a new appearance does not guarantee an improved life.

___3. When removal of pouches around the eyes is desired, eyelid surgery (blepharoplasty) may be done in conjunction with the brow lift.

___4. Endoscopic brow lift surgery will not remove small wrinkles around the eyes or remove any discoloration or skin blotches.

___5. If I use tobacco, I agree to cease use of tobacco for 2-3 weeks prior to and after surgery. Failure to do so may have serious negative effects on the success of my surgery.

___6. I have been advised and understand that this is not a minor surgical procedure.

___7. Additionally, I have been advised and understand that Aesthetic surgery will not cease the aging process. Future and additional surgeries may be necessary, depending upon aesthetic and cosmetic considerations. Surgical results may not match expectations and anticipations.

SURGICAL CONSIDERATIONS

___8. Endoscopic brow lift/ Midface surgery require the placement of incisions between hair follicles behind the hair line. Each incision is from front to back in direction and is 1 inch to 2 inches in length. 5 to 6 incisions will be placed depending on your treatment plan. Each incision is closed with numerous stainless steel staples which are removed in10-14 days.

___9. Incision inside the mouth will also be made to perform the Midface procedure.

__10. Neck lift incision is 2-3cm hidden under the chin.

__11. Facelift incisions are into side burns, in front, behind the ears and into the hair behind the ears.

__12. The Midface will also be elevated and secured in place using Endotine Midface Fixation device (Brochure given _____). This device may sometimes be palpable prior to resorption. It may also require removal due to discomfort, infection, erosion through the skin, reaction or other concerns.

__13. Every reasonable attempt will be made to place incisions along natural skin lines and creases. In many cases, incisions will result in some scarring, which usually fade and become less visible as healing occurs. Some patients will experience temporary or permanent loss of hair at the incision sites. For those patients, a second procedure (scar revision) may be indicated.

POST-OPERATIVE CONSIDERATIONS

__14. At the conclusion of surgery, your hair will be washed, blow-dried, and ointment placed on the wounds. A tennis headband will be placed, and must be worn at the correct position at all times as directed by your doctor.

__15. Cotton head wrap is also worn for 48 hours when a neck lift is performed.

__16. Post-operative discomfort and headache is typical and can be controlled with medications.

__17. Swelling and bruising of the surgical areas is common and may last for two or three weeks. Keeping the head elevated for several days after surgery will help reduce such complications. Swelling may not completely resolve for up to six months, but the duration and intensity varies with each individual. Patients often report a feeling of tightness, which is described as being uncomfortable. Healing is a gradual process and the final result may not be realized for six to twelve months.

__18. As a result of surgery and repositioning of the facial skin, some numbness can be expected. Such numbness is usually temporary, lasting from six to twelve months. In some cases, there can be residual areas of permanent numbness.

__19. Post-operatively I understand I must avoid excessive or strenuous exercise such as aerobics, heavy lifting, or other strenuous activities.

RISKS AND COMPLICATIONS

__20. It has been explained to me that there are certain inherent and potential risks in any surgical procedure and that in this specific instance such operative risks include, but are not limited to:

___A. Delayed healing. In very rare instances, necrosis (loss of localized areas of skin) may occur. This complication may require additional treatment and surgery.

___B. Infection and localized collections of blood are not uncommon. Minor blood clots will be drained locally; major hematomas may require deeper surgical drainage. When indicated, antibiotics will be prescribed. In rare cases, infection may require additional treatment or hospitalization.

___C. Poor healing may result in excessive and permanent scarring which may require a second operation for scar revision.

___D. Blood loss is usually minimal; however, in rare cases, a transfusion may be necessary. I understand my rights regarding donation of my own blood before surgery so it may be transfused back to me if necessary.

___E. Nerve damage: the surgery will involve areas of certain cranial or facial nerves. Damage to sensory nerves may cause numbness, usually temporary. However, in rare cases, such numbness of the skin may be permanent. Additionally, there is a risk of damage to nerves that affect motor function. For example, there may be an inability to raise the eyebrows, smile, etc... Decreased function of motor nerves may also be permanent in nature.

___F. There may be localized hair loss, which may require further treatment.

___G. Other risks include:

_____

_____

___21. ANESTHESIA

Cosmetic surgery is most commonly performed in a hospital, but may be done in an outpatient clinical setting. In the latter event, a choice of anesthetics is offered. The anesthetic I have chosen for my surgery is:

Local Anesthesia
Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
Local Anesthesia with Oral Premedication
Local Anesthesia with Intravenous Sedation
General Anesthesia

__22. ANESTHETIC RISKS include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

__23. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**

___A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.

___B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

___C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK **FOR** EIGHT (8) HOURS PRIOR TO YOUR ANESTFIETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**

___D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

NO GUARANTEE OF TREATMENT RESULTS

__24. 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 is a risk of failure or relapse, my condition may worsen, and selective re-treatment may be required in spite of the care provided.

__25. I have had an opportunity to discuss my past medical and social history, including drug and alcohol use, with my doctor and I have fully informed him of all aspects of my health history, recognizing that withholding information may jeopardize the planned goals of surgery.

__26. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that any lack of cooperation can result in a less-than-optimal result, or may be life threatening.

__27. If any unforeseen condition should arise during surgery that may call for additional or different procedures from those planned, I authorize my doctor to use surgical judgment to provide the appropriate care.

__28. I consent to the taking of photographs, video or audio recordings and agree to be interviewed for medical, scientific, or education purposes. Filming or photographing an operation may include my face and may reveal my identity.

DERMABRASION, LASER RESURFACING OR CHEMICAL PEEL
Pigment changes (lightening or darkening of all or patches of skin), which can possibly be permanent. Scarring which can be hypertrophic (thickened and/or raised). Prolonged redness. activation of herpetic lesions. _____ (patient's initials)

INFORMATION FOR FEMALE PATIENTS ONLY: Anesthetic agents can be harmful to the fetus of a pregnant woman. General anesthesia should be avoided during pregnancy whenever possible. I hereby state that I am not pregnant and accept the responsibility of making this determination._____(patient's initials)

DO YOU SMOKE? YES / NO (Circle one)

THIS PARAGRAPH PERTAINS TO SMOKERS - Smokers are recognized to have a significantly higher risk of postoperative wound healing problems as well as operative and postoperative bleeding. Patients should discontinue smoking for two weeks after surgery. Although it helps to stop smoking for several weeks before and after surgery, this does not eliminate the increased risk resulting from long-term smoking. _____ (Pt's initials)

CONSENT

I certify that I have had an opportunity to fully read this consent, and that all blanks were filled in before signing. I also certify that I speak, read, and write English. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient's (or Legal Guardian) Signature Date

Doctor's Signature Date

Witness' Signature Date