Merheb Surgical Arts

EYELID SURGERY CONSENT (BLEPHAROPLASTY)

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 conditions:_____
_____

The procedure(s) to treat those conditions has/have been described as:_____
_____

___1. Eyelid surgery (blepharoplasty) is the procedure used to remove excessive folds of eyelid skin, pouches under the eyes and, in some instances, is accompanied by an additional procedure to correct sagging brows. After consultation regarding my particular needs, my doctor has informed me of the extent of my proposed surgery. I understand that the procedure involves incisions in the upper and/or lower eyelid at locations based upon my doctor's surgical judgment.

___2. Eyelid surgery can be performed under local anesthesia (numbing of the area), often in conjunction with pre-operative sedation, intravenous sedation or general anesthesia to help relieve anxiety.

___3. I have been advised and I understand that there is no guarantee that eyelid surgery will improve my appearance or correct any pre-existing condition.

___4. I have been completely candid and honest with my surgeon regarding my motivation for undergoing eyelid surgery, and realize that a new appearance of my eyes does not guarantee an improved life.

___5. If I use tobacco, I agree to cease all 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.

SURGICAL CONSIDERATIONS

___6. Incisions will be made in the upper and/or lower eyelids, which will follow natural lines and creases, and usually extend into the fine wrinkles (crows feet) at the outer edge of the eye. Underlying compartments of fat are then removed and, in some cases, excess skin and muscle tissue will also be removed.

POST-OPERATIVE CONSIDERATIONS

___7. Some post-operative discomfort should be expected, which can be modified somewhat by the application of cold dressings. Any discomfort is usually controlled with medications, which will be provided. It is important to keep your head elevated for several days to help reduce expected swelling and bruising. You will receive other instructions about the use of eyewashes and eye drops after surgery.

___8. A certain amount of bruising (black and blue discoloration) and swelling can be expected for several days after surgery. Dryness of the eyes may persist for a few months. Eyelid surgery may improve, but not eliminate, fine wrinkling of the outer edges of the eyes (crows feet). You should avoid strenuous activity such as exercise, heavy housework, bending or lifting, etc. for several weeks. It is often advisable to wear dark glasses for a few weeks after surgery to protect the eyes from sun and wind irritation.

___9. The incisions will be closed with small sutures. Usually the scar lines are small and eventually are almost unnoticed. However, scarring is unpredictable and in certain individuals the incision lines may require a second procedure to attempt to reduce scarring.

___10. I have been advised and I acknowledge that there is no guarantee that the procedure will improve my appearance. Patients react differently depending upon age, health and skin elasticity, and some individuals may require additional procedures to remove or tighten excess skin. Furthermore, some individual skin may tend to wrinkle more than others. Aging will continue and there may be a future need for this same surgery.

RISKS AND COMPLICATIONS

___11. It has been explained to me that there are certain inherent and potential risks in any surgical treatment and that in this specific instance such operative risks include, but are not limited to:

___ A. Corneal abrasion or other eye injury.
___ B. Excessive bleeding, particularly in patients with high blood pressure.
___ C. Difficulty in closing the eyelids post-operatively due to swelling.
___ D. Residual dryness of the eyes.
___ E. Infection that may require antibiotic therapy and, in rare cases, hospitalization.
___ F. Due to individual patient differences, there may be asymmetry of the eyelids (eyes not appearing equal in size).
___ G. Some numbness of the skin of the eyelid may occur. Usually it is temporary, but may rarely be permanent.
___ H. In some cases, the lower eyelids may need taping for support during healing. Some patients may require a second procedure to correct residual sagging of the lower lids.
___ I. In some cases, the lower eyelid may appear to turn outward. Such a response to surgery is unpredictable and a second corrective procedure may be required.
___ J. Bleeding may occur behind the eye that can lead to permanent blindness if not corrected within a short time. If required, such surgery is done in the hospital. I have been told that I MUST notify my doctor immediately if undue pain or swelling develops around my eyes, or if I have any change in vision.

___12. **ANESTHESIA**

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

___13. **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.

___14. **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 **SIX (6) HOURS** PRIOR TO YOUR ANESTHETIC. **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 sip of water.**

NO GUARANTEE OF TREATMENT RESULTS

___15. 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, selective re-treatment may be necessary, or my condition may worsen in spite of the care provided.

___16. I have had an opportunity to discuss with my doctor my past medical and social history, including any serious problems, drug, alcohol and tobacco use, and have provided full details. I recognize that the withholding of information may jeopardize the surgical result.

___17. I agree to cooperate fully with my doctor's recommendations while I am being treated, realizing that lack of cooperation can result in a less-than-optimal result, or may be life threatening.

___18. If any unforeseen condition should arise in the performance of the operation that calls for my doctor's professional judgment to perform different or additional surgery from what is described above, I authorize my doctor to provide appropriate care.

___19. I consent to the taking of photographs, video or audio recordings and agree to be interviewed for medical, scientific, or educational purposes. Filming or photographing an operation may include my face and may reveal my identity.

INFORMATION FOR FEMALE PATIENTS

___1. I have advised my doctor about my use of birth control pills. I understand that certain antibiotics and other medications are known to neutralize their effect and that conception and pregnancy can occur. I agree to consult with my family physician to initiate other forms of birth control during the period of my treatment for eyelid surgery until my physician advises me that I can return to the exclusive use of birth control pills.

CONSENT

I certify that I have had an opportunity to fully read this consent, and that all blanks were filled in before my 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's) Signature _____ Date _____

Doctor's Signature _____ Date _____

Witness' Signature _____ Date _____