CONSENT FORM FOR ONCOPLASTIC BREAST SURGERY

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

_____ _____

Patient's Initials or Authorized Representative Date

I, _____ hereby authorize Patricia Clark, M.D., and any associates or assistants the doctor deems appropriate, to perform oncoplastic breast surgery.

The doctor has explained to me the potential benefits of the procedure. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I understand the doctor may decide to change the surgical plan before or during the procedure if she feels this is necessary, and I consent to such procedures as she determines are appropriate, with the exception of _____. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well-being and safety.

I understand there is risk to all surgery and that complication rates with Oncoplastic Breast Surgery can exceed fifty percent (50%) for some types of procedures. **These complications include, but are not limited to:** ***recurrence of cancer, increased frequency of breast biopsy after surgery, fat necrosis, necrosis of skin or breast tissue, loss of skin flaps, complete or partial loss of nipple areola complex, infection, bleeding, hematoma (pooling of clotted blood), seroma, nerve damage, inability to breast feed, change or loss of nipple color, nipple and skin numbness or change in sensation, poor or irregular position or shape of nipples and areola, heavy or poor scar, keloid scar, skin irregularity, prolonged wound healing, wound separation, poor cosmetic appearance, breast deformity, partial or complete loss of breast, pain, or anesthesia reaction. Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize. Even without the occurrence of these listed complications, additional surgeries may be required.*** _____

initial

Reasonable alternatives to this procedure have been explained to me. These alternatives may include, but are not limited to: mastectomy, radiation, chemotherapy, endocrine therapy, surgical tumor removal without oncoplastic or other reconstruction, surgical tumor removal with reconstruction planned at a later date, or surgical tumor removal with reconstruction by a plastic surgeon either immediately or at a later date.

In permitting my doctor to perform the procedure, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure or a different procedure than that already explained to me. I therefore authorize and request that the above-named physician, her assistants, or her designees perform such procedure(s) as necessary and desirable in the exercise of her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician or covering physician will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

I understand the risk of complication is increased in patients with medical diseases such as diabetes, obesity, connective tissue disorders or tobacco use.

I have not smoked or used nicotine products for two (2) months prior to surgery. _____
initial

I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis or other diseases.

I hereby authorize the doctor to utilize or dispose of removed tissues, parts or organs resulting from the procedure authorized above.

I consent to have photographs taken before and after my surgery. I understand these photographs will remain in my permanent medical record, and that they may be used for educational purposes. I understand that my identity will be protected and not revealed if my photographs are used for educational purposes. I also consent to the release of these photographs to third parties (such as insurance companies) as necessary.

I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

_____ _____ _____/_____
Signature of Patient or Authorized Representative | Relationship | Date | Time

❑ The Patient/Authorized Representative has read this form or had it read to him/her.

❑ The Patient/Authorized Representative states that he/she understands this information.

❑ The Patient/Authorized Representative has no further questions.

_____ _____/_____
Signature of Witness | Date | Time

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

Physician:_____ Date/Time_____/_____

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____Foreign language (specify)

_____Sign language

_____Patient is blind, form read to patient

_____Other (specify)_____

Interpretation provided by _____
(Fill in name of Interpreter and Title or Relationship to Patient)

_____ _____/_____
Signature (Individual Providing Assistance) Date Time