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CONSENT FOR BREAST ASYMMETRY SURGERY

We think it is important that you understand not only the benefits of the surgery you are going to undertake but also all of the risks. For this reason, we have composed this informed consent for you to read and sign. If this information raises any questions, please call or come in to the office so that we can discuss things further.

I, _____, hereby authorize Dr. Bashioum and his staff to perform a surgical operation for correcting the differences in size and/or shape of my breasts, known as breast asymmetry surgery. This will include repositioning of my nipples known as breast lift or mastopexy and possibly breast enlargement.

Dr. Bashioum and the staff at the Bashioum Cosmetic Surgery Center, Ltd. have personally explained breast asymmetry surgery to me. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I completely understand the nature and consequences of the procedure. The following points, among others, have been specifically made clear.

Based on Food and Drug Administration (FDA) decisions, both saline filled implants and silicone gel filled implants are available to me for implantation. Research indicates that the material implanted in the body does not cause malignancy in human subjects. There is a possibility although rare that my body may not tolerate these implants, making it necessary to remove the implants.

Alternate treatment methods have been explained. These include but have not been limited to smooth and rough implant surfaces, round and contoured shapes, submuscular and subglandular placement, and alternate implant fillings including soy oil, silicone gel, and saline or salt water. The risks and benefits of each of these have been explained to me.

The incision will heal with a permanent scar. Placement of the scar around the areola and beneath the breast has been discussed. The advantages and disadvantages have been explained.

The procedure is subject to the same postoperative complications as other surgical procedures. Infection, bleeding, abnormal scarring, poor healing, slow healing, skin loss, nerve damage, and/or muscle damage can occur. It has been made clear to me that although rare, it is possible to experience loss of the nipple and the dark skin around the nipple known as the areola.

It is normal for my body to form scar tissue also known as a capsule around the implant. If this scar tissue becomes tight around the implant, the breasts may feel firm or hard. This condition is also known as capsular contracture and may be permanent as long as the implant is in place. Rarely this condition can cause me pain, discomfort, and/or breast deformity. I may be able to feel or see the margin of the implants or wrinkles in the implant.

No guarantee has been given or implied to me as to size and shape of the breasts. It is possible that I will want one or both implants to be made larger, made smaller, or repositioned to give a more acceptable result in my eyes. I may also choose to have surgery to make the scars less noticeable or reposition the nipples.

Postoperative bleeding may occur around the implant requiring a second operation for its removal. If not removed, this blood collection will lead to breast firmness, possibly infection and/or skin loss.

After being exposed to cold temperatures (e.g., swimming in cold water), my breasts may feel cooler than surrounding body tissues.

Absence of feeling, decreased feeling, and/or undesirable sensations of my nipples or breast skin may be experienced following surgery. I am aware that these permanent changes occur 15% of the time. This may interfere with breast feeding and/or sexual arousal.

The implant shell will break at some point in the life of the implant. These implants are not permanent. A failure rate of as high as 1% per year may be experienced. At the end of 50 years all women will need to have one or both implants replaced at least once.

There will be scar tissue left in the breast after surgery. This scar tissue may interfere with the interpretation of mammograms and mimic the appearance of breast lumps on mammograms. This may require excision in the future.

All breast implants interfere with mammograms. Soy oil filled implants interfere much less than saline filled implants. I understand that submuscular placement interferes less as well. As before this surgery, I acknowledge the necessity to do monthly breast self-exams in an effort to detect breast masses early. Also, I will inform mammogram technicians of my past surgery so that they can do extra x-rays to make up for my implants interfering with mammograms. On rare occasions, the presence of breast implants may delay the diagnosis of breast cancer. This may make it impossible to cure the breast cancer.

I understand that my breasts are different sizes and different shapes. This is the reason I am choosing to have this surgery. Even though the surgery is designed to reduce these differences, there will always be some differences in my breast size and shape.

I have been given free choice of the breast implant size to be used for this surgery. I have chosen a size that I feel is appropriate for my body shape. We have discussed the feasibility of placement of this size with regards to safety and appearance. I understand that the final decision of implant size will be made at the time of surgery based on safety and appearance.

I am not pregnant now nor will I be pregnant at the time of surgery. Pregnancy is not recommended for at least six (6) months after the surgery. It is impossible to predict any changes in my breasts with future pregnancies.

I have not nor will not use any illegal drugs prior to my surgery. I understand that these can lead to unexpected responses during the surgery that can result in death. I have also informed Dr. Bashioum and the staff of the Bashioum Cosmetic Surgery Center, Ltd. of all the prescription and nonprescription drugs including herbal or natural treatments that I have been taking.

I recognize that, during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore further authorize and request that Dr. Bashioum and the staff at the Bashioum Cosmetic Surgery Center, Ltd. perform such procedures as are, in his professional judgment, necessary and desirable, including, but not limited to, procedures involving pathology and radiology. The authority granted under this Paragraph shall extend to remedying conditions that are not known to Dr. Bashioum and the staff at the Bashioum Cosmetic Surgery Center, Ltd. at the time the operation is started.

I consent to the administration of local anesthesia, intravenous sedation, and or general anesthesia to be applied by or under the direction and supervision of Dr. Bashioum.

I recognize that when general anesthesia is used and it presents risks over which the above doctors and staff have no control. I agree to discuss the risks of intravenous sedation and general anesthesia with the nurse anesthetist before surgery is performed. I understand that a nurse anesthetist will provide all of my anesthetic care.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made or implied to me as to the results of breast enlargement and breast lift surgery. I understand that it is not possible to control the healing process. I understand that during the year after my surgery there is a 10% chance of a second surgery being required to give me the result that I want.

I consent to be transferred to any available hospital at the discretion of my doctors in the event that such transfer is necessary.

I understand that while receiving care a health care worker may accidentally be exposed to my blood or other bodily fluid. If this rare event occurs, I understand that my blood will be tested for the presence of infectious diseases, including HIV, the AIDS virus. This test is necessary to help protect and counsel the health care worker. I understand the results of the test will be part of my medical record and will not be released except with my prior consent or as required or permitted my law.

I consent to be photographed before, during, and after the treatment. These photographs shall be the property of the Bashioum Cosmetic Surgery Center, Ltd. These photographs may be **published** in scientific journals, **shown** for scientific reasons, and/or used in **patient education** both in and out of the office.

I agree to keep the Bashioum Cosmetic Surgery Center, Ltd. informed of any change of address so that they can notify me of any late findings, and I agree to cooperate with the Bashioum Cosmetic Surgery Center, Ltd. in my care after surgery until completely discharged.

I am not known to be allergic to anything except: _____ . I am not allergic to latex. I have never had high fevers associated with any anesthesia.

I HAVE READ THE ABOVE CONSENT AND RECEIVED A COPY OF IT. ALL OF MY QUESTIONS HAVE BEEN ANSWERED AND I FULLY UNDERSTAND THE CONTENTS OF THE CONSENT AND AUTHORIZE AND REQUEST DR. BASHIOUM AND THE STAFF OF THE BASHIOUM COSMETIC SURGERY CENTER, LTD. TO PEFORM BREAST ASYMMETRY CORRECTION SURGERY ON ME.

Patient: _____ Date: _____

Witness: _____ Date: _____