CONSENT FOR BLEPHAROPLASTY WITH OR WITHOUT LASER

If you have any questions, please ask your surgeon before signing.

Section A: Blepharoplasty Acknowledgement

1. Eyelid surgery (blepharoplasty) is the procedure used to remove excessive folds of eyelid skin, pouches under the eyelids 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.
2. I understand that the procedure involves incisions in the upper and/or lower eyelid at locations based upon my doctor's surgical judgment.
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 to my eyes does not guarantee an improved life.
5. If I use tobacco, I understand that I must cease all such use at least two weeks prior to surgery. Failure to do so may have serious negative effects on the success of my surgery such as improper healing of my scars, infection, even necrosis of tissues. I am aware my surgery will take place at Scotia Surgery Inc., an accredited facility located in Dartmouth.

Section B: Surgical Considerations

1. Incisions will be made in the upper and/or lower eyelids that will follow natural lines and creases, and usually extend into the fine wrinkles (crow's 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.
2. I have had an opportunity to discuss with my doctor my past medical and social history, including any serious health problems, drug, alcohol, tobacco use or any ASA type medication taken, also including birth control pill. I have provided full details and recognize that the withholding of information may jeopardize the surgical result.
3. I agree to have preoperative and postoperative photos taken for my records as well as for use in medical, scientific, educational and promotional purposes. My name will not be used on any such photographs.

Section C: Post-Operative Considerations

1. A certain amount of bruising and swelling can be expected for several days after surgery. Dryness of the eyes and blurred vision may persist for a few months. Eyelid surgery may improve, but not eliminate, fine wrinkling of the outer edges of the eyes (crow's 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.
2. The incisions will be closed with small sutures. Usually the scar lines are small and eventually are almost unnoticed. However, scarring is unpredictable. 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's skin may tend to wrinkle more than others. Aging will continue and there may be a future need for this same surgery.

Section D: Risks and Complications

1. 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 the following:

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 rarely may be permanent. In some cases, the lower eyelids may need taping for support during healing.

1. Some patients may require a second procedure to correct residual sagging of the lower lids. In some cases, the lower eyelid may appear to turn outward. Such a response to surgery is predictable and a second corrective procedure may be required. In some cases, some small skin necrosis can result requiring a surgical modification.

2. In fat repositioning procedures: asymmetry of fat position, loss of tissue transfer, cutaneous defect, skin necrosis, ectropion, hypertrophic scar, incomplete or over correction, vision change, some cases, the lower eyelid may appear to turn outward. Such a response to surgery is predictable and a second corrective procedure may be required.
3. 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.**

Section E: Anesthesia

The anesthetic I have chosen for my surgery is: (a) Local Anesthesia_____ (b)Local with Oral Premedication______(c) Local with Intravenous Sedation_____ (d) General Anesthesia_____

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.

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 is usually 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 ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
D. However, it is important that you take any regular medications (high blood pressure medicine, antibiotics, etc.) or any medications prescribed by this office, **using only a sip of water.**

Section F: No Guarantee of Treatment Results:

1. No guarantee or assurance has been given to me that the proposed treatment will 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 retreatment may be required in spite of the care provided.
2. I have had the opportunity to discuss my past medical and social history, including drug and alcohol use, I have also informed my surgeon of all medication taken, especially any ASA type. I have fully informed my surgeon of my health history and recognize that withholding information may jeopardize the planned goals of surgery.
3. I agree to cooperate fully with my surgeon's recommendations while under treatment, realizing that any lack of cooperation can result in a less-than-optimal result, **or may be life threatening.**
4. If any unforeseen condition should arise during surgery that may call for additional or different procedures from those planned, I authorize my surgeon to use surgical judgment to provide the appropriate care.
5. **I understand that the surgeon's fees are separate** from the anesthesia and facility charges, and the fees are agreeable to me. **If a secondary procedure is necessary, further expenditure will be required.**
6. This facility is a member of the Canadian Association for Accreditation of Ambulatory Surgical Facilities and as part of the requirements your chart will be retained and may be subject to peer review for quality control by the Canadian Association for the Accreditation of Ambulatory Surgical Facilities.

Consent

I agree to have both preoperative and postoperative photos taken for my records as well as for use in medical, scientific, educational and promotional purposes. My name will not be used on any such photographs.

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 read, speak 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**