

CONSENT FOR FACIAL IMPLANT and GENIOPLASTY



The surgery planned for you is designed to change the position/contour of your cheeks, chin or jaw, and it is important that you understand the benefits and risks of such surgery. This is NOT minor surgery and you have the right to be fully informed about your condition and the recommended treatment plan. The disclosures in this consent are not meant to alarm you, but rather to provide information you need in order to give or withhold your consent to the planned surgery.

Dr. Bourget has described my condition as: _____

The surgical procedure planned to treat the above condition has been explained to me, and I understand the nature of the treatment to be: _____

I have been informed of possible alternative forms of treatment (if any), including fillers, fat grafting if appropriate.

Section A: Acknowledgment

Facial implants are specially formed solid, biocompatible materials designed to enhance or augment the physical structure of the face. The most common sites for facial implants are, the cheekbones, chin, and the jaw. Facial implants can bring balance and better proportion to the structural appearance of the face, and they can help define the face by increasing projection and creating more distinct features. It is important to remember that the human face is normally asymmetric to some degree and your results may not be completely symmetric.

Section B: Post-Operative Considerations

1. Swelling and bruising of the face 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 everyone. Patients often report a feeling of tightness, which is described as uncomfortable.
2. Healing is a gradual process and the final result may not be realized for six to twelve months.
3. 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. Post-operatively I understand I must avoid excessive exercise such as aerobics, heavy lifting, or other strenuous activities (2-4 weeks).

My doctor has explained to me that there are certain potential risks and side effects of my planned surgery, some of which may be serious. They include, but are not limited to:

Section C: Specific Risks and Complications

Degradation of facial implants: It is possible that small pieces of implant material may separate from the outer surface of facial implants. This is of unknown significance and has not been shown to result in disease.

Implant Extrusion: Lack of adequate tissue coverage or infection may result in exposure and or extrusion of the implant. If tissue breakdown occurs and the implant becomes exposed, implant removal may be necessary.

Nerve Injury: Motor and sensory nerves may be injured during facial implant surgery. Weakness or loss of facial movements in the mouth or upper eyebrow, resulting in an uneven appearance, may occur after surgery. Permanent numbness is rare, and most individuals will notice a return to motor function. Injury can also occur to the sensory nerves of the face, neck and ear regions. Permanent numbness or painful nerve scarring is rare; however, it can occur.

Chronic Pain: Very infrequently, chronic pain may occur after facial implant surgery.

Infection: and localized collections of blood are not uncommon. Minor blood clots will be drained locally, major hematomas may require surgical drainage. In rare cases, infection may require additional treatment or hospitalization.

Scarring: Although good wound healing after a surgical procedure is expected, abnormal scars may occur within both the skin and the deeper tissues. Scars may be unattractive and of different color than the surrounding skin. There is a possibility of visible marks from sutures. Additional treatments including surgery may be needed to treat scarring.

Unsatisfactory Result: There is a possibility of an unsatisfactory result from the facial implant surgery. The surgery may result in unacceptable visible or tactile deformities, loss of function, or structural malposition. You may be disappointed that the result of facial implant surgery does not meet your expectations. Future surgery may be necessary should the result of facial implant surgery be unsatisfactory. Partial healing of damaged structures prior to placement of facial implants may interfere with the optimal result from surgery.

Section D: General Risks of Surgery

1. Bruising and discoloration of the skin and gum tissue around the lips, jaw, face and neck.
2. Allergic reaction to any of the medications given during or after surgery.
3. Asymmetry, implant displacement, and/or thick scar tissue around the implant (capsular contracture).
4. Relapse: the tendency for the repositioned bone segments to return to their original position, which may require additional treatment, including surgery and or bone grafting.
5. A change in cosmetic appearance, not every aspect of which can be exactly predicted. There may be decreased function of muscles of facial expression in the area of surgery.
6. Possible need for additional procedures to remove fixation devices such as pins, screws, plates or splints.
7. Post-operative infection that may cause loss of adjacent bone and/or teeth and may require additional treatment for a prolonged period of time.
8. Discomfort in the jaw joints (TMJ) resulting in some change in chewing difficulties or bite changes usually of a temporary nature but may be permanent.
9. Stretching of the corners of the mouth causing cracking with resulting discomfort and slow healing.
10. Inflammation of veins (phlebitis) that are used for IV fluids and medications, sometimes resulting in pain, swelling, discoloration and restriction of arm or hand movement for some time after surgery.
11. I realize the importance of providing true and accurate information about my health, especially concerning pregnancy, allergies, medications (including "natural" remedies and vitamin therapy) and history of drug, tobacco or alcohol use. If I misinform my surgeon, I understand the consequences may adversely affect the results of my surgery and could be life threatening.
12. I understand that oral hygiene will be difficult following surgery but will do my utmost to follow normal tooth brushing and oral hygiene routines.
13. Revision surgery, although rare, is a possibility with any cosmetic procedure. Post-operative touch ups are usually minor and most often performed with local anesthesia. A surgical fee will be charged commensurate with the extent of the revision.

Section E: Anesthesia

I consent to the administration of, ____ Intravenous Sedation, or ____ General Anesthesia, having first had the risks and benefits of each explained to me.

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.

PATIENT 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 ANESTHETIC. TO DO SO MAY BE LIFE-THREATENING!**
- D. However, it is important that you take any regular medications (high blood pressure, 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 re-treatment may be required in spite of the care provided.
- 2. I have had an opportunity to discuss my past medical and social history, including drug and alcohol use, also have informed my surgeon of all medication taken, especially any ASA type. I have fully informed my surgeon of all aspects of my health history and recognize **that withholding information may jeopardize the planned goals of surgery.**
- 3. 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.**
- 4. 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.
- 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 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