re*be Skin & Vein Clinic
P.O. Box 125
1008 East View Ave. Unit 8
Okoboji, Iowa 51355

(712) 332-6001
(712) 332-LIPO
(712) 332-6010 fax

BREAST AUGMENTATION SURGERY CONSENT

I, _____, (Patient Name) hereby authorize Dr. Ronald J. Kolegraff MD, FACS and his assistants to perform upon me the following operation or procedure:

Breast Augmentation/ Breast Enlargement

I understand that, I am required to have my mammogram, lab results and surgical bra in Dr. Kolegraff's office before I can have my surgery.

I certify that the nature and purpose of the Breast Augmentation and the risks involved, possible complications and alternative methods of treatment have been fully explained to me by Dr. Kolegraff. I completely understand the nature and consequences of the procedure. Among the possible risks and complications discussed with by Dr. Kolegraff were the following:

I understand that the operation or procedure will require incisions which heal with scar tissue and that these scars are permanent. The incision lines are usually conspicuous immediately after surgery and for an indefinite period of time. I understand that healing abilities vary from person to person and the individual response cannot be accurately predicted prior to surgery.

I understand that there will be swelling and discoloration for an indeterminate period of time which will normally disappear in a few days but may require several weeks or even months to completely disappear.

I understand that there will be black and blue marks on or about the breasts and chest wall, which are usually visible for several weeks but can last longer in some patients.

I understand that following surgery, there may be areas of numbness involving the breasts and nipples which may persist for an indefinite period of time. I also understand that sometimes fluid or blood may accumulate in the operative sites which would require aspiration or drainage.

I understand that this operation carries the usual potential dangers of any operation which includes infection, bleeding, scarring, adhesions, and problems with wound healing.

I understand that this operation carries the usual potential dangers of any procedure involving anesthesia of any type; although much less so with tumescent anesthesia.

I understand that in 100% of patients who undergo breast augmentation, a fibrous capsule forms around all breast implants. In approximately 30% - 50% of cases, the fibrous capsule will require a future surgical procedure to either remove the capsule completely or to release the tension caused by the fibers.

I understand that leaks or ruptures may occur in the wall of the implant, resulting in deflation of the implant and that such a situation will require another surgical procedure to remove the damaged implant and replace it with a new implant.

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I understand that rippling can often occur with saline implants. Rippling is a sensation of fluid waves under the breast, but in most cases, this does nto affect the visual aesthetic result.

I understand that stretch marks may appear on the skin of my breasts following augmentation surgery.

I understand that although the function of lactation (milk production) is usually preserved, it can occasionally be permanently lost.

I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures than set forth above. I, therefore, authorize and consent to the performance of such additional operations or procedures that Dr. Kolegraff considers therapeutically necessary or desirable on the basis of findings during the course of the operation. The authority granted herein permits Dr. Kolegraff to correct conditions that were not known or apparent prior to the beginning of the operation or procedure.

I understand that other physicians might recommend a different procedure and that I am free to seek the advice of any physician or physicians I might choose. Prior to signing this document, I have taken the time to consider whether or not I wish to ask any further questions of Dr. Kolegraff or whether I desire to obtain a second opinion from another physician. I understand that by signing this document, I voluntarily and of my own choice select to undergo the operation or procedure listed above.

I authorize Dr. Kolegraff to retain, preserve and use for scientific or therapeutic purposes or to dispose of, in accordance with the customary practice, any specimen or tissues taken from my body during this operation or procedure.

I consent to be photographed and/or videotaped before, during and after treatment and understand t hat these photographs and/or video shall be the property of Dr. Kolegraff and may be published in scientific journals and/or shown for scientific reasons.

I am aware that the practice of medicine and surgery and in particular cosmetic surgery is not an exact science. I acknowledge that, due to the nature of this operation or procedure, an exact end result cannot be predicted and that Dr. Kolegraff has made no guarantees or promises of specific result from this operation or procedure.

I have received and signed for a special information sheet about this surgical procedure.

I understand that touch up procedures are occasionally needed in cosmetic surgery.

I understand that my breast augmentation will be performed under local tumescent anesthesia.

I authorize Dr. Kolegraff and whoever may be delegated as assistants to prescribe the use of such anesthetics as he or she may deem necessary or advisable.

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I understand that Dr. Kolegraff is a general surgeon and not a plastic surgeon.

I understand that Dr. Kolegraff has initiated a new program of cosmetic awake breast augmentation as early as 2014.

I understand that I am approximately patient number _____ in this new cosmetic awake breast augmentation program.

I certify that I have read and fully understand the above authorization and I intend to be legally bound hereby:

_____ _____
Signature Date

_____ _____
Witness Date