



CONSENT FOR BUCCAL FAT REDUCTION

Please initial each paragraph after reading. If you have any questions, please ask the staff BEFORE initialing.

The buccal fat pads lie on each side of the cheek and extend from the temple to the lower jaw. Reduction of this fat is a common procedure to slim the face. This is a moderate result and not a procedure that will duplicate a major body weight loss. The goal of this surgery is to reduce the cheek fat in a subtle manner. It is important not to take out all the fat, but rather to provide a reduction. The area that is affected by the surgery is the lower cheek that is lateral to the corners of the mouth and the result is generally not noticeable in the high cheek or temple regions.

I have been informed that I have the following conditions: Buccal Fat Pad excess

The procedure(s) to treat those conditions has/have been described as: Buccal Fat Pad reduction

____ 1. Buccal Fat Pad reduction is the surgical technique used to remove localized collection of fat beneath the skin. I understand that the purpose of my surgery is to attempt to improve the appearance of localized areas on my body.

____ 2. I have been completely candid and honest with my doctor regarding my motivation for undergoing Buccal Fat Pad reduction, realizing that a new appearance does not guarantee an improved life.

____ 3. I have provided my doctor with a complete and accurate medical and social history, realizing that withholding certain information may adversely affect my diagnosis and treatment and the final result of my surgery.

____ 4. It has been explained to me that Buccal Fat Pad reduction is a surgical technique suitable for selected patients. It is not a substitute for weight reduction that can ordinarily be obtained by dieting and exercise, and it is not a cure for obesity.

____ 5. It has also been explained to me that my physical condition may require surgical lipectomy in which excess skin and fat may be removed instead of, or in addition to, Buccal Fat Pad reduction.

____ 6. If I use tobacco, I understand that this could complicate surgery, anesthesia, healing, results, and longevity.

SURGICAL CONSIDERATIONS

____ 7. The technique of Buccal Fat Pad reduction has been explained to me. I understand that it may be performed under local anesthesia or in conjunction with the use of intravenous sedation or a general anesthetic.

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Small incisions are made in selected locations. I have been advised that additional or larger incisions may be necessary to gain adequate access to all areas of unwanted fat.

POST-OPERATIVE CONSIDERATIONS

____ 8. All incisions are closed with small sutures; however, slight scarring may be expected. I have been advised that in some patients, scarring is unpredictable and may be more noticeable. If necessary, a secondary procedure may be performed to attempt to minimize scarring.

____ 9. After surgery a snug dressing of elastic gauze will be applied to the surgical areas to help conform the skin to the shape of the underlying tissues. Some bruising and swelling may persist for several weeks after surgery. Some post-operative discomfort can be expected, and medications will be prescribed to provide adequate relief.

____ 10. I have been advised and understand that patients react differently to Buccal Fat Pad reduction, depending upon age and health. Some individuals have different skin elasticity and may require additional procedures to remove or tighten excess skin. Further, some patients' skin may tend to wrinkle more than others. The anticipated result in a minor to moderate reduction of the cheek fat.

____ 11. I will avoid strenuous physical activity, exercise, etc. for at least two weeks after surgery.

RISKS AND COMPLICATIONS

____ 12. My doctor has 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:

____ A. The possibility of a second surgery/procedure in the event an abundance of excess fat is encountered.

____ B. Ordinarily, Buccal Fat Pad reduction does not cause excess bleeding that would require blood transfusion. Nevertheless, there is the remote possibility of blood transfusion and I understand that I may donate my own blood before surgery so that it may be transfused back to me if necessary.

____ C. I understand that surgery involves the risk of numbness of the skin overlying the area of fat removal. In most cases, this condition is temporary, but in rare cases may be permanent.

____ D. It is possible that after fat removal of the overlying skin will not be smooth, but may appear to have a "wash-board" appearance. A second cosmetic procedure may be necessary to attempt correction of this condition.

____ E. Fat removed from the cheek area, has a risk of injury to the nerves that control the muscles of facial expression, causing a loss of facial tone and decreased function. This condition is usually temporary, but may be permanent.

____ F. Any surgery involves the risk of infection that may require antibiotic treatment. Most infections resolve without complication, but, in rare instances, treatment may involve hospitalization and may affect the planned outcome of the surgery.

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____G. There is a possibility of localized collection of blood (hematoma) in the areas of fat removal. Secondary surgical procedures may be necessary to drain those areas.

____H. I understand that the parotid duct (the tube that drains saliva into the mouth) could be damaged and result in salivary gland or saliva retention and require additional surgery to repair.

____I. I understand that excessive removal of fat could result in a hollow now or in the future and could require further treatment.

____J. I understand that the result may not be as dramatic as I desire, and that lack of result or asymmetry may result.

____13. **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.

____14. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**

- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult who will 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 SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
- D. **However**, it is important that you take any regular medication (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

NO GUARANTEE OF TREATMENT RESULTS

____15. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or meet every expectation. Due to individual patient differences, there is a risk of failure or relapse, my condition may worsen, and selective re-treatment may be required despite the care provided.

____16. I have had an opportunity to discuss my medical and social history, including drug and alcohol use, with my doctor. I have informed him of all aspects of my health history, recognizing that withholding information may jeopardize the planned goals of surgery.

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_____17. 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.

_____18. If any unforeseen condition should arise during surgery which may call for additional or different procedures from those planned, I authorize my doctor to use surgical judgment to provide the appropriate care.

_____19. 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 in accordance with the extent of the revision at the discretion of the surgeon.

_____20. I certify that the alternatives to the procedure have been discussed.

INFORMATION FOR FEMALE PATIENTS

_____21. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return to the use of birth control pills.

CONSENT

I certify that I have had an opportunity to fully read the terms of this consent, and that all blanks or statements requiring insertions were filled before my signing. I also certify that I speak, read 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 Signature: _____

Date: _____



Witness' Signature: _____

Date: _____