

MASTECTOMY

A mastectomy is the surgical removal of the entire breast, usually to treat serious breast disease, such as breast cancer. There are four general types of mastectomy. A SUBCUTANEOUS MASTECTOMY removes the glandular breast tissue but leaves the envelope of breast skin, nipple, and areola (the pigmented circle around the nipple) in place. A TOTAL (OR SIMPLE) MASTECTOMY is the removal of the entire breast but not the lymph nodes under the arm (axillary nodes). In a MODIFIED RADICAL MASTECTOMY, the whole breast and most of the lymph nodes under the arm (axillary nodes) are removed. Removal of these lymph nodes is called an axillary dissection. RADICAL MASTECTOMY involves removal of the chest wall muscles (pectorals) in addition to the breast and axillary lymph nodes.

Patient's
Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of mastectomy have been discussed with me and may include but are not limited to:

- *bleeding*
- *compromised blood supply/loss of skin*
- *emotional distress*
- *infection*
- *injury to nearby tissues, muscles, nerves*
- *limited shoulder motion after radical mastectomy*
- *necessity of revisional procedures*
- *possible recurrence of cancer*
- *scarring*
- *seroma*
- *when lymph nodes are removed:*
 - numbness of axilla and down arm*
 - pain in axilla and down arm*
 - swelling of the arm and hand*

_____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.

_____ I understand and accept the risks of blood transfusion(s) that may be necessary.

_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

_____ The doctor has answered all of my questions regarding this procedure.

Continued

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, M.D., with associates/assistants of his/her choice, to perform a (SUBCUTANEOUS/TOTAL/MODIFIED RADICAL/RADICAL) (circle one) mastectomy on _____ at _____, on my
(name of patient) (name of facility)

right breast

left breast

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

Physician Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial