ABDOMINOPLASTY
Post Bariatric Surgery
Abdominal Reconstruction

Abdominoplasty, or “tummy tuck,” is a major surgical procedure designed to remove excess skin and fat from the lower abdomen and may involve tightening of muscles of the belly wall. Post bariatric surgery and successful large weight loss produces excess skin and fat that form rolls, folds, or an “apron” requiring removal. This procedure inevitably involves large and sometimes unsightly scars. These are inevitable and their final appearance depends on your own genetic healing characteristics that have little to do with the surgery. Occasionally, other complications may also occur.

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 abdominoplasty have been discussed with me and may include but are not limited to:

- allergic reactions
- asymmetries of contour
- bleeding
- change in sensation or numbness of abdominal skin
- changes in shape or appearance of pubic hair
- delayed healing
- disappointment
- “dog ears” (skin excess at scar end)
- extended hospital stay
- failure to alleviate symptoms of rash and back pain
- genital region numbness

_____ 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 understand that skin and tissue relaxation may follow plastic surgery after weight loss. This natural loosening or stretching of skin after surgery is unpredictable, and may require additional surgery.

_____ I am aware that smoking during the three to four week pre- and postoperative periods is prohibited as smoking could dramatically 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 or implied. Additionally, I understand that abdominoplasty (panniculectomy) done to relieve symptoms of skin irritation and/or back pain is not a cosmetic operation.

I have been advised of the probable consequences of declining the 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.

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

I authorize and direct _______________________________, M.D., with associates or assistants of his or her choice, to perform abdominoplasty on _______________________________ at _______________________________.

(name of facility) (patient name)

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 treatment and the risks and consequences of not proceeding, have offered to answer any questions and have fully answered all such questions. I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

copy given to patient

original placed in chart

initial

initial

3/03

Revised 9/05, 12/05, 1/06, 6/07

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).