The use of tissue expanders for breast reconstruction commonly involves a two-stage process. A tissue expander is inserted and then filled over time to increase the size of the breast mound. A second operation is performed to place a breast implant. As implants and expanders cannot be expected to last forever, there is a high probability of future revisionary surgery.

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 breast reconstruction/augmentation following tissue expansion have been discussed with me and may include but are not limited to:

- asymmetry
- bleeding
- calcification causing pain and firmness
- capsular contracture (hardening)
- change in skin and nipple sensation
- chest wall deformity
- eventual implant displacement
- future removal/replacement of implants
- implants fail—break, leak, etc.
- infection
- scarring
- seroma requiring draining
- skin wrinkling and rippling
- unsatisfactory results

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 breast implant may make mammography more difficult and may obscure the detection of breast cancer.

I understand that I will not be able to breast feed on the side in which the mastectomy was performed and that, although many women with breast implants have successfully breast fed their babies, it is unknown if there are increased risks for children of women with breast implants.

I am aware that smoking during the pre- and postoperative periods will 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 have been advised that I should avoid taking any aspirin, aspirin-containing products or anti-inflammatory medications for 10 days prior to surgery to help reduce the risk of bleeding.

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.

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 or assistants of his or her choice, to
perform reconstructive breast augmentation with tissue expanders on _______________________
at ______________________________ on my: _______________________
                                 (name of facility)  (name of patient)

☐ 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, benefits, risks, complications, and alternatives to the
proposed procedure to the patient or the patient’s legal representative. 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                                                 _______ original placed in chart
initial                                                                                    initial