

## BROWLIFT SURGERY

*Browlift surgery is meant to improve the appearance of drooping eyebrows, eyelid hooding, forehead furrows, and frown lines. There are two surgical methods: the first is the most conventional method, where a surgical incision is hidden just above the hairline. The second is performed using an endoscope, which enables the procedure to be performed with a minimal number of incisions. While the traditional method can sometimes attain more lift, both methods can create smoother, flatter skin on the forehead.*

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

- allergic reaction to tape, sutures or topical preparations
- asymmetry of the eyebrows (often present preoperatively)
- bleeding
- fluid under the skin (seroma/hematoma)
- hair loss or thinning around incisions
- infection or accumulation of blood requiring evacuation
- irritation or dryness of the eye (often temporary)
- itching of the scalp
- lumps/irregularities under the skin that may resolve over a few months
- mild residual frown lines
- pain
- possible diminished or absent sensation to the forehead or scalp (often temporary)
- ridging of the scalp skin
- scarring
- skin loss requiring further reconstructive surgery
- unsatisfactory result
- weakness or paralysis of the muscles and nerves that elevate the brow or close the eye

\_\_\_\_\_ 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 take any or all of these medications on the days surrounding the procedure.

\_\_\_\_\_ (For endoscopic browlift only) I understand that if my doctor becomes concerned during the course of the procedure, he/she may find it necessary to create a standard forehead incision ("coronal," or ear-to-ear across the top of the head) in order to correct the problem.

\_\_\_\_\_ I understand the coronal incision(s) may result in some numbness and itching of the upper scalp that may slowly resolve over several months.

\_\_\_\_\_ I understand the coronal incision(s) may result in patchy numbness that may be permanent.

\_\_\_\_\_ I understand the coronal incision(s) will result in a permanent scar.

*Continued*

- \_\_\_\_\_ 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.
- \_\_\_\_\_ 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 the following procedure of \_\_\_\_\_ browlift on \_\_\_\_\_  
(traditional or endoscopic)  
 \_\_\_\_\_ at \_\_\_\_\_.  
(patient name) (name of facility)

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 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