

MID-FACE LIFT

A mid-face lift or “cheek lift” is surgical procedure designed to improve the look of the cheekbone area as well as the area underneath the eyelids. It is designed to restore fullness to these areas. 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 mid-face lift surgery 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 facial skin*
- *changes in shape or appearance of the eyelid area (extropion)*
- *delayed healing*
- *disappointment*
- *extended hospital stay*
- *facial nerve interference and numbness*
- *hematoma (blood clots under skin)*
- *infection*
- *loss of skin from insufficient circulation (requiring further surgery and skin graft)*
- *nerve interference with decreased closure of the eye*
- *bruising*
- *need for more surgery for secondary surgical corrections*
- *pain (may be prolonged)*
- *permanent scars that may be unsightly*
- *unsightly or disfiguring scars*
- *pulmonary embolism (blood clots in the lung)*
- *seroma (fluid collection under the skin)*

_____ 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.

_____ 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.

Continued

_____ 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 procedure of mid-face lift on _____ at _____.
(Facility name) (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 procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial