

## NIPPLE RECONSTRUCTION SURGERY

*Nipple reconstruction involves the restoration of the nipple-areolar complex lost due to injury, breast cancer, or other condition. A variety of different techniques exists for reconstruction of the nipple and its surrounding areolar tissue. These include the use of skin grafts taken from other regions of the body, local flaps of breast skin that are shaped into a nipple, or the sharing of tissue from the opposite nipple-areolar region. Additional techniques, such as tattooing, may be used to add color to the tissue.*

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 nipple reconstruction surgery have been discussed with me and may include but are not limited to:
- *bleeding*
  - *damage to opposite nipple if tissue is borrowed*
  - *hair growth from skin graft*
  - *inability to breast feed*
  - *inability to match color if tattooing*
  - *infection*
  - *long term alteration to contour and appearance*
  - *loss of nipple sensation*
  - *scarring*
  - *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 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 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.

*Continued*

I authorize and direct \_\_\_\_\_, M.D., with associates or assistants of his or her choice, to perform nipple reconstruction on \_\_\_\_\_ at \_\_\_\_\_, on my:  
(patient name) (name of facility)

right nipple

left nipple

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