

OPEN CAPSULECTOMY WITH BREAST IMPLANT EXCHANGE

Breast implants do not have an indefinite life span and often require replacement surgery. Open capsulectomy with breast implant exchange is a surgical operation performed to treat capsular contraction, which occurs around breast implants, and/or to place new breast implants. Depending on the extent of the internal scarring, it may be necessary to place the new implants in a deeper location, underneath the pectoralis muscle on the chest.

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 open capsulectomy with breast implant exchange have been discussed with me and may include but are not limited to:

- *bleeding*
- *calcification, causing pain and firmness*
- *change in nipple/skin sensation*
- *damage to adjacent tissue, muscle, or chest wall*
- *degradation of breast implant*
- *eventual implant displacement*
- *implant rupture or leakage*
- *inability to remove capsular scar tissue*
- *infection*
- *recurrent capsular contracture*
- *scarring*
- *seroma/fluid build up requiring drainage*
- *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 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.

Continued

- _____ 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 open capsulectomy with breast implants on _____ at _____, on my: _____
(name of facility) (patient name)

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, 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