BLEPHAROPLASTY
(Eyelid Surgery)

Blepharoplasty is a surgical procedure to correct drooping upper eyelids and puffy bags below the eyes by removing excess fat, skin, and muscle.

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

- additional corrective surgery
- allergic reaction to tape, sutures or topical preparations
- asymmetry in healing or scarring
- bleeding
- bruising
- decrease in sensation of eyelid skin or impaired eyelid function
- dryness, irritation, burning, itching of eyes
- formation of whiteheads
- hematoma, post operative blood clot collection
- infection
- pain
- pulling down of lower lids
- scarring
- swelling
- temporary blurred or double vision
- temporary difficulty in closing eyes completely
- temporary discomfort
- temporary excessive tearing, sensitivity to light
- tightening of lids
- unsatisfactory result

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 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, especially scarring.

Although extremely rare, postoperative impairment of vision or blindness has been reported.

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.

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 the 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.

Continued
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 blepharoplasty on __________________________ on __________________________ at __________________________.

(name of facility)  (name of patient)

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 _____ original placed in chart

initial  initial