BREAST IMPLANT REMOVAL

Breast implant removal is accomplished by opening the breast and removing the implant from either behind the breast tissue or under the breast muscle.

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

- implant rupture and inability to remove 100% of the residual silicone from the breast cavity
- inability to breastfeed
- infection, hematoma (swelling or blood mass), or scarring
- loss of breast tissue resulting in loss of breast sensation
- loss of interest in sexual relations by either myself or my partner
- scar contractures precluding reconstruction later
- severe psychological disturbance, including depression
- strong negative impact on my physical appearance, including distortion, wrinkling, and significant loss of volume, and/or an appearance worse than prior to the initial augmentation

_____ 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.

_____ 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 the removed implant will be examined and sent to pathology, if necessary.

_____ I understand that if the implant is intact, I may take it with me, or it will be destroyed.

_____ 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 the following procedure of breast implant removal on ______________________ on my:               (name of facility)

☐ 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 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

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).