BREAST RECONSTRUCTION
WITH TRAM ABDOMINAL MUSCLE FLAP

The TRAM (transverse rectus abdominis muscle) flap technique of breast reconstruction involves the use of abdominal muscle flap(s) made from rectus abdominal muscle. This muscle and a portion of lower abdominal skin and other tissue are repositioned to the chest wall region in order to construct a breast mound. The muscle flap maintains its own blood supply and helps nourish the tissue that is transferred. In some cases, an implant may be attached underneath the muscle flap to give the breast mound additional projection. If it is determined and agreed that an implant should be used, an additional and separate consent for the implant must be used.

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 reconstruction with tram abdominal muscle flap have been discussed with me and may include but are not limited to:

- abdominal wall hernia
- asymmetry
- bleeding
- change in skin sensation
- delayed healing and loss of flap
- fat necrosis
- firmness from internal scarring
- infection
- pulmonary complications
- scarring
- seroma requiring draining
- unsatisfactory results
- weakness in abdominal muscle function

_____ 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 the reconstructed breast cannot be expected to look exactly like the opposite breast and some degree of asymmetry is expected.

_____ I understand that I will not be able to breast feed on the side in which the mastectomy was performed.

_____ 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 reconstructive breast augmentation with TRAM abdominal muscle flap on ________________________________ at ________________________________ on my.

☐ 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 fully understands what I have explained.

_____________________________
Physician Signature/Date/Time

_____ copy given to patient  _____ original placed in chart
initial  initial