BROWLIFT SURGERY

Browlift surgery is meant to improve the appearance of drooping eyebrows, eyelid hooding, forehead furrows, and frown lines. There are two surgical methods: the first is the most conventional method, where a surgical incision is hidden just above the hairline. The second is performed using an endoscope, which enables the procedure to be performed with a minimal number of incisions. While the traditional method can sometimes attain more lift, both methods can create smoother, flatter skin on the forehead.

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

- allergic reaction to tape, sutures or topical preparations
- asymmetry of the eyebrows (often present preoperatively)
- bleeding
- fluid under the skin (seroma/hematoma)
- hair loss or thinning around incisions
- infection or accumulation of blood requiring evacuation
- irritation or dryness of the eye (often temporary)
- itching of the scalp
- lumps/irregularities under the skin that may resolve over a few months
- mild residual frown lines
- pain
- possible diminished or absent sensation to the forehead or scalp (often temporary)
- ridging of the scalp skin
- scarring
- skin loss requiring further reconstructive surgery
- unsatisfactory result
- weakness or paralysis of the muscles and nerves that elevate the brow or close the eye

[ ] 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.

[ ] (For endoscopic browlift only) I understand that if my doctor becomes concerned during the course of the procedure, he/she may find it necessary to create a standard forehead incision (“coronal,” or ear-to-ear across the top of the head) in order to correct the problem.

[ ] I understand the coronal incision(s) may result in some numbness and itching of the upper scalp that may slowly resolve over several months.

[ ] I understand the coronal incision(s) may result in patchy numbness that may be permanent.

[ ] I understand the coronal incision(s) will result in a permanent scar.

Continued
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.

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 the following procedure of __________________________ browlift on __________________________ (traditional or endoscopic) at __________________________.

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