INFORMED SURGICAL CONSENT

CONSENT FOR SURGERY, PROCEDURE, OR TREATMENT

Please read this form carefully and ask your surgeon about anything that is unclear. Your signature confirms that your procedure, its benefits, risks, and alternatives have been explained to you and that your questions have been answered.

PATIENT & PROCEDURE

I, _____ (patient name) , authorize **Dr. Henry Sandel** and / or **Dr. Claire Duggal**

to perform the following procedure(s) or treatment(s), together with all indicated procedures:

_____

_____

☐ I have received the following procedure information sheet(s): _____

! **Before you sign.** Surgery is elective and its results cannot be guaranteed. The sections below describe what you are authorizing, the risks involved, and realistic expectations for healing. Initial each page and sign only when you fully understand and agree.

AUTHORIZATION & ANESTHESIA

1. **Authorization.** I authorize my surgeon to perform the procedure(s) described above, along with any additional procedures they judge to be necessary or advisable during my care.

2. **Unforeseen conditions.** If unexpected conditions arise during surgery, anesthesia, or treatment, I authorize my surgeon to perform such different or additional procedures as they consider necessary in their professional judgment for a safe and satisfactory outcome — including conditions not known before the procedure began.

3. **My surgical team.** My surgery will be performed by my surgeon. I understand that trained assistants may take part in the procedure when necessary.

4. **Anesthesia.** I consent to the anesthetics my care team considers necessary or advisable. I understand that all forms of anesthesia carry risk and the possibility of complications, including injury; dental or airway (oropharyngolaryngeal) trauma; heart or lung events; stroke; and, rarely, death.

RESULTS, HEALING & EXPECTATIONS

5. **No guarantee of results.** No one has given me any guarantee about the result of my surgery. Outcomes vary with many factors, including conditions found during surgery and how my body heals.
6. **Realistic outcomes.** Even with my surgeon's best effort, my result may differ from what I expect. The goal of elective surgery is meaningful improvement; a "perfect" result is subjective and is not a realistic expectation.
7. **Swelling & recovery time.** Swelling and bruising are expected. They can be prolonged and, in some cases, permanent, and full healing may take months to years.
8. **Scarring.** Scars and scar tissue are a normal part of surgery and healing and can sometimes produce undesirable results. The healing process is different for every patient and is not fully within my doctor's control.

SURGICAL RISKS

9. **Common risks.** I understand that the risks of surgery and healing include, but are not limited to, the following:

- Bleeding and infection
- Scarring, distortion, and/or asymmetry
- Pain, numbness, or tingling
- Anesthesia complications
- Sagging, lumps, and contour irregularities
- Nerve damage (motor and/or sensory)
- Fluid collections (hematoma, seroma, abscess)
- Changes in taste, smell, voice, or swallowing
- Runny or dry nose; oily or dry skin
- Death
- Damage to surrounding or deeper structures
- Wound separation and delayed healing
- Allergic reactions
- Tightness of the treated area
- Color changes of the skin
- Blood-vessel trauma
- Life-threatening events (heart attack, stroke, embolism, blood clots, meningitis, CSF leak)
- Changes in vision, excess tearing, or dry eyes
- Skin loss or necrosis; fistula
- The need for further procedures or surgeries

CONSENT TO CARE PRACTICES

10. **Photography & video.** I consent to photography or video of my procedure(s) for medical, educational, and documentation purposes, provided my name and identity are not revealed by the images.

11. **Observers.** I consent to approved observers being present in the operating room solely to learn from my surgeon.

12. **Disposal.** I consent to the disposal of any tissue or medical devices removed during my procedure.

13. **Release of information.** I authorize the release of my Social Security number to the appropriate agencies for required legal reporting, medical-device registration, and billing when applicable.

14. **Sharing concerns.** If I have any concerns, I agree to discuss them directly with the doctors and staff at The Sandel Duggal Center for Plastic Surgery rather than through online reviews.

15. **Right to decline.** I understand I may ask questions at any time and may decline or stop treatment after discussing it with my provider.

IT HAS BEEN EXPLAINED TO ME IN A WAY I UNDERSTAND:

- The treatment or procedure to be undertaken
- That alternative procedures or methods of treatment may exist
- That there are risks to the proposed procedure or treatment

I consent to the treatment or procedure and to items 1–15 above. I requested and received, in substantial detail, further explanation of the procedure or treatment, of other alternative procedures or methods of treatment, and of the material risks involved. All of my questions have been answered to my satisfaction.

SIGNATURES

Patient or person authorized to sign for patient _____ Date _____

Witness signature _____ Date _____

Surgeon's signature _____ Date _____