**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**2019-2020**

**Consent form for Acne Scar Surgery**

(Please acknowledge the source when using this consent form)

**Mr/Mrs./ Miss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: Date:**

**Case Record No:**

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis:**

**Name of the PROCEDURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyelid being operated – Right upper/ Right lower/ Left upper/ Left lower**

**I have been informed that**

* The purpose of Blepharoplasty is to remove excess tissue from the upper and lower eyelids. It can improve drooping skin and bagginess. This can improve vision in older patients who have hooding of their upper eyelids and project a more youthful appearance.
* Blepharoplasty does not remove “crow’s feet or other wrinkles or dark circles under the eyes, and neither lifts sagging eyebrows.
* It does not address issues affecting the functioning of the eyelid like dropping eyelid from impaired muscle functioning (ptosis) or outward turning of the eyelids (ectropion).
* This surgery is generally performed under local anaesthesia, which involves giving a few injections near the eyes which will numb the area. The procedure is expected to be painless thereafter.
* It can be performed on upper, lower or both eyelids.
* Like any other surgery this surgery also involves certain risks. Some of them are bleeding/bruising, infection, scarring, damage to deeper structures like nerves, asymmetry of the eyes, ectropion, excessive exposure of the eyelid, allergic reaction to stiches material or any topical medicines applied in the eyelid area. Very rarely blindness may occur if there is internal bleeding around the eye.
* Some amount of bruising is expected. However, if severe then a repeat surgery may be required to remove the accumulated blood. The risk of bleeding may increase if I am on any blood thinners or if I am hypertensive.
* Blepharoplasty does not reverse the aging process so I may require repeat surgery to maintain the results.
* Smoking, tobacco products, or nicotine products (patch, gum or nasal spray) use increases the risk for significant surgical complications of skin dying, delayed healing and additional scarring.
* Following is my current status regarding smoking
	+ \_\_\_\_\_\_\_ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.
	+ \_\_\_\_\_\_\_ I am a smoker or use tobacco/ nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.
* It is important to refrain from smoking at least 6 weeks before surgery.
* I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
* After surgery, few stitches will be put which may be of self-dissolving type or I may have to visit after 5-7 days for stitch removal.
* During this time, I am supposed to avoid strenuous physical activity which may increase the chance of bleeding.
* Post-surgery I may require ice packs to reduce the swelling.
* Post-surgery I will have to wash my face 2-3 times daily and apply antibiotic ointment over the stitches.
* I may not be able to go to work/drive for a few days post-surgery.
* In case of severe pain, swelling, or diminished vision I need to immediately call my doctor.
* Post-surgery I am supposed to sleep in supine position for at least a week.

**Additionally**

* I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however, my name or identity will not be disclosed and complete confidentiality will be maintained.
* By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the possible risks of blepharoplasty.
* I have informed the doctor about any/all drug allergies that I have.
* Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.
* I also agree to comply with the recommended after-care instructions.

**Consent**

I hereby release Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and his/her designated staff from liability associated with the above procedure.

My questions regarding the procedure have been answered satisfactorily.

I authorize Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and his/her designated staff to perform Blepharoplasty on my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_eyelid.

The payment and fee structure have been informed to me and I agree to abide by the same.

**SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE (in case of minor)**

**Name:**

**SIGNATURE OF WITNESS SIGNATURE OF OPERATING DOCTOR**

**Name: Name:**

**Date: Time: Place:**

**Was Translation to the Patient’s language required: Yes/ No**

**SIGNATURE OF THE TRANSLATOR**

**(Name and Relationship with the patient, if any)**