



**LOWE PLASTIC SURGERY**

**ACKNOWLEDGEMENT & INFORMED CONSENT  
FOR THE INCREASED RISK OF RADIATION & COMPLEX MEDICAL CONDITIONS  
ON SURGICAL RECONSTRUCTION**

I understand that I have a medical condition that includes radiation that may significantly impact the risks and potential complications of the proposed procedure or treatment plan. I understand that my medical problems, past medical history, overall health, or medications may significantly impact my recovery and increase my overall risk of surgery. I have discussed with my surgeon and my other physicians these risks and decided to proceed with this elective or non-elective procedure.

I am fully aware that I have a medical condition that required radiation to the surgical site that increases my risk of inter-operative and post-operative complications. I know that radiation may result in delayed wound healing and implant complications such as infection, fluid collections, extrusion, or implant loss. I also know that medications that I take may also have a negative impact on my recovery. Radiation, medications, or any other conditions that impact my immune system, delay wound healing, or increase my risk of surgery have been reviewed and their exact impact can not be fully determined in advance of surgery. Some of these conditions or previous treatments may result in complications or compromise that may limit my recovery, result in further surgery, cause extensive wound complications, and result in significant morbidity. Radiation or other complex medical conditions could also result in an increase risk of cardiac or pulmonary compromise, infection, or even death.

**Examples of medications that increase my risks include:** Coumadin, Aspirin, Plavix, Heparin, Elmiron-1C, Fragmin, Lovanox, Aggrenox, Persantin, Corticosteroids (Prednisone), Multivitamins, Anti-oxidants, Isotretinoin (Accutane), Herbal Medications, Immune Regulators, Immune Suppression Agents, Radiation, Chemotherapy Medications (Efudex, Aldara), Anti-cholinergics, Parkinsonian Agents, Anti-rheumatic Agents, Biologic Response Modifiers (Humira, Keneret, Embrel, Remicade), Disease Modifying Anti-rheumatic Drugs (Azathioprine, Hydroxychloroquine, Methotrexate), Nicotine, etc.

I understand that the above and other medications increase my risk of surgery and that these medications should be modified when possible to decrease major complications. I also understand that I should discuss with my prescribing doctor the best way to modify these medications to decrease my risks without compromising my overall medical condition. I understand and agree that I should not undergo surgery if one of my physicians has expressed serious concerns or disagrees with the having either an elective or non-elective procedure. I agree to avoid medications as instructed to the best of my ability before, during, and after surgery and to discuss modifications or changes in drug regimes with my surgeon whenever possible. I believe that I have been fully informed of these risk and desire no further educational information at this time.

I also understand that the safety and effectiveness of surgery in combination with radiation and the above medications or medical conditions continues to be studied and the risk can not be fully understood. I understand that reading and fully understanding the materials and consents provided is required, and that I have consulted with my treating physician prior to undergoing surgery when indicated or recommended.

**(Review and respond to second page questions)**

**By circling the correct response and signing below, I acknowledge:**

- Y/ N I have had adequate time to read and fully understand all educational information
- Y/ N I have had an opportunity to ask my surgeon any questions I may have about the effects of pre-operative or post-operative radiation on my surgery and recovery.
- Y/ N I am aware that radiation has a negative effect on my surgery and recovery. I know that it increase my risk of surgical complications such as delayed healing, wound complications, skin loss, implant failure, fluid collections, infection, and even death.
- Y/ N I have had an opportunity to ask my surgeon any questions I may have about this material or any other issues related to risk of medications, my medical condition, and radiation.
- Y/ N I have considered the alternatives to surgery and have decided to precede with surgery in light of these increase risks.
- Y/ N I have been advised to wait an adequate amount of time after reviewing and considering all educational materials, before scheduling my surgery; and
- Y/ N I will retain a copy of the pertinent educational materials, and I am aware that I may also ask my surgeon for a copy of this or other signed acknowledgments.

\_\_\_\_\_  
PATIENT (PRINT NAME)

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATED

**By my signature below, I acknowledge that:**

- My patient has been given an opportunity to ask any and all questions related to the educational materials, or any other issues of concern;
- All questions outlined above have been answered “Yes” by my patient;
- My patient has had adequate amount of time before making their final decision; and
- Increased risk of surgery and specifically increase risk of medications and radiation was reviewed and Patient Consent has been reviewed and signed.

\_\_\_\_\_  
SIGNATURE OF SURGEON

\_\_\_\_\_  
DATED