# TOM J. POUSTI, MD, F.A.C.S.

PLASTIC AND RECONSTRUCTION SURGERY

## INFORMED CONSENT BRACHIOPLASTY (DERMOLIPECTOMY OF THE ARM)

1. I hereby authorize **Tom J Pousti, MD**, to perform the following surgery know as Brachioplasty or Dermolipectomy of the arm.

2. I have met with the doctor personally, and the procedure has been explained to me by the above doctor. I understand the nature and consequences, including possible risks of the procedure.

3. The following risks and side effects, among others, have been specifically made clear to me:

   a. There will be swelling for an indeterminate period, but much of the swelling will normally disappear in a few days and the remainder may require several weeks or even months to completely disappear.

   b. There are always scars following an incisional procedure. Every effort will be made to make them as inconspicuous as possible.

   c. Surgery necessary to perform the procedure, like all surgery, involves certain general risks, including, but not limited to, the following::

      1. Bleeding
      2. Infection
      3. Tissue damage
      4. Nerve injury
      5. In rare cases, death or other serious bodily injury

4. It has been explained to me all the possible complications of these two operations including hematoma, seroma, infection, skin irregularity, skin laxity, skin laxity may require secondary Brachioplasty, loss of sensation, prolonged hyperemia of the scar at the sight of the suction and changes in pigmentation.

5. I understand the possibility of delayed wound healing, skin loss, dog ears which may require secondary revision, hypertrophy of scarring or keloid and hyperemic scarring for 1 to 1/2 years.

6. I consent to the administration of anesthetics considered necessary or advisable. I understand that all forms of anesthesia involves risks and the possibility of complications, injury and sometimes death.

7. I acknowledge that no guarantee has been given by anyone as to the results that may be

 **Patient Initials**_____

obtained.

8. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by pictures.

I have had sufficient opportunity to discuss this condition and treatment with the doctor and/or his associates, and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to give an informed consent to the proposed treatment.

Patient_____Date_____Witness_____

Please give the name, address, and telephone number of someone who is aware that you are having this surgery.

Name_____

Address_____

Phone_____



**Patient Initials_____**