Informed Consent

Breast Implant Removal

INSTRUCTIONS

This is a document about informed consent. This well tell you more about your breast implant removal surgery. You will learn about the risks and other treatment options.

It is important that you read the whole document carefully. Please initial each page. Doing so means that you have read the page. Signing the consent agreement means that you agree to the surgery that you have talked about with your plastic surgeon.

GENERAL INFORMATION

Surgery is needed to remove breast implants. This may be a simple implant removal without removal of the capsule tissue around the implant. Or the surgery may have more procedures such as:

- Removal of the capsule tissue around your breast implant (capsulectomy)
- Removal of leaked silicone gel in your breast tissue (extracapsular, or outside the capsule layer) from silicone implants (breast biopsy)
- Breast lift (mastopexy following breast implant and/or capsule removal)

Broken or damaged implants cannot be repaired. Surgery is needed to remove or replace the implants. You may be able to choose either general or local anesthesia for breast implant removal.

There are both risks and possible issues with this surgery.

If you choose to have revisions made to your breast implants, you must sign other consent documents also. This document is for the permanent removal of breast implants and/or capsule tissue around the implants, or a breast biopsy to remove leaked silicone gel.

If you choose to have a breast lift at the same time of breast implant removal, you must sign another informed consent document.

OTHER TREATMENTS

There are other treatment options. These include not having surgery at all, or having other procedures to replace, relocate, or revise existing implants. These options have their own risks and issues. You should discuss these with your doctor.

RISKS OF BREAST IMPLANT REMOVAL SURGERY

All surgeries have some risk. It is important that you know these risks. You must also understand other issues that might come up during or after surgery. Every procedure has its limits. Choosing to have a surgery means comparing the risks and benefits. Most patients do not face problems, but you should talk about them with your plastic surgeon. Make sure you know all possible risks of breast implant removal.

______ **Patient Initials**

©2020 American Society of Plastic Surgeons®

©2021 Echelon Surgical Specialists

SPECIFIC RISKS OF BREAST IMPLANT REMOVAL SURGERY

Skin Wrinkling:

Wrinkling of the breast skin can occur. These may be visible, felt, or both. More surgery may be needed to tighten loose skin after breast implants are removed. Your breasts will have much lesser volume after implants are removed.

Asymmetry:

Your breasts may not be symmetric after this procedure. Removal of implants does not include tightening the skin or removing extra skin and asymmetry of the breasts is highly likely.

Unhappy with Appearance:

You may be unhappy with the appearance of your breasts after removal of breast implants. You may not like the ways your breasts look after the operation. You may not like the appearance of your skin after surgery. Skin that has been stretched out with breast implants may not appear the way you want it to. Your breasts will likely not be symmetric after this procedure.

Informed consent documents are not meant to define or serve as the standard of medical care. Standards of medical care are determined based on the facts involved in an individual case. They may change with advances in science and technology. They can also change with the ways doctors practice medicine and evolve.

It is important that you read the above information carefully and get all your questions answered before signing the consent agreement on the next page.

______ **Patient Initials**

©2020 American Society of Plastic Surgeons®

©2021 Echelon Surgical Specialists

CONSENT FOR PROCEDURE OR TREATMENT

1. I hereby authorize Dr. Matthew C Camp and such assistants as may be selected by the physician to perform the following procedure or treatment**: Removal of Breast Implants.**
2. I have received the following information sheet: Breast Implant Removal.
3. I understand that, during the procedure or treatment, unforeseen conditions may require the use of different procedures or treatments than those above. Therefore, I authorize the above physician, assistants and/or designees to perform such procedures or treatments that are necessary or advisable, as determined by the above physician's professional judgment. The authority granted under this paragraph includes all additional procedures or treatments that are not known to my physician at the beginning of the above procedure or treatment.
4. I understand what my surgeon can and cannot do, and understand that there are no warranties or guarantees, implied or specific, about the outcome of the procedure(s) or treatment(s). I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not realistic. All my questions have been answered, and I understand the inherent (specific) risks to the procedure(s) or treatment(s), as well as the additional risks and complications, benefits, and alternatives. Understanding all of this, I choose to proceed with the procedure or treatment.
5. I consent to the use of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.
6. I am aware that there are potential significant risks to my health with the use of blood products, and I consent to their use should they be deemed necessary or advisable by my physician, assistants and/or designees.
7. I consent to the disposal of any tissue, medical devices, or body parts that may be removed during or after this procedure or treatment, or any additional procedures or treatments that are necessary or advisable.
8. I consent to be photographed or televised before, during, and after the procedure(s) or treatment(s), including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures.
9. For purposes of advancing medical education, I agree that observers may be admitted into the operating room.
10. I authorize the release of my Social Security Number to appropriate agencies for legal reporting and medical device registration, as applicable.
11. I agree to the charges associated with this procedure or treatment. I also understand that there may be additional charges if additional procedures or treatments are necessary or advisable, and I agree to those charges, if any.
12. I realize that not having the procedure or treatment is an option, and that I can opt out of having this procedure or treatment.
13. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
    a. THE ABOVE PROCEDURE OR TREATMENT TO BE UNDERTAKEN
    b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
    c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE SURGERY AND THE ITEMS THAT ARE LISTED ABOVE (1-13).
I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS.

____
Patient or Person Authorized to Sign for Patient — Date/Time

____
Matthew C Camp, MD — Date/Time

______ **Patient Initials**

©2020 American Society of Plastic Surgeons®
©2021 Echelon Surgical Specialists