BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Blepharoplasty

This information is given to you so that you can make an informed decision about having **Blepharoplasty.**

Reason and Purpose of the Procedure
This is a surgical procedure to remove excess skin and muscle from the eyelid. It can be done to either or both upper and lower eyelids.

Benefits of this Procedure
You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the possible benefits are worth the risk.

- Improve drooping skin and bagginess.
- Improved vision for those with hooding of upper eyelids.

Risks of Procedure
No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

Risks of this Procedure

- **Infection**. May require antibiotics or additional surgery.
- **Blindness caused by bleeding around the eye**. This is rare.
- **Skin scarring.** More treatment including surgery may be needed.
- **Chronic eye pain**.
- **Dry eye problems caused by decreased tear production.** This is rare.
- **Damage to other structures may occur-nerves, muscle, blood vessels.** This may be temporary or permanent.
- **Difficulty closing eyelids after surgery.** Additional treatment or surgery may be needed.
- **Asymmetry**. Each eyelid may look different after surgery. Slow healing.
- **Allergic reactions to medication given, tape, suture or topical preparation.** Additional treatment would be required.

Risks Associated with Smoking
Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications, clot formation, skin loss, or wound healing delays.

Risks Associated with Obesity
Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You

_____

_____

_____

_____

Alternative Treatments
Other choices:

- Do nothing. You can decide not to have the procedure.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

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By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Blepharoplasty.**
- I understand that other doctors, including medical residents or other staff may help with surgery or procedure. The tasks will be based on their skill level. My doctor will supervise them.

Patient Signature_____Date:_____Time:_____
Relationship: ☐Patient ☐Closest relative (relationship)_____ ☐Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter:_____Date_____Time_____
Interpreter (if applicable)

For Provider Use ONLY:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature:_____ Date:_____ Time:_____

Teach Back
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:
____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____

OR
____ Patient elects not to proceed: _____ Date:_____ Time:_____
(patient signature)
Validated/Witness:_____ Date:_____ Time:_____