BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Reduction Mammoplasty

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

Reason and Purpose of the Procedure

Women who have large breasts may experience problems from the weight and size of their breasts. They may have back, neck, and shoulder pain and skin irritations. Reduction mammoplasty involves removal of excess breast tissue. The surgeon usually does this by making a curved incision under the breast and removing tissue. The skin is pulled taut and the nipple moved to its normal position in the center of the breast. The goal is to give the woman smaller breasts in proportion with the rest of her body.

Benefits of this Surgery or 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.

- minimize back, neck and shoulder pain.
- improve sleep.
- improve activity.
- improve rash and skin irritation.

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.

General Risks of Surgery or Procedure

- **Small areas of the lungs may collapse.** This would increase the risk of infection. This may need antibiotics and breathing treatments.
- **Clots may form in the legs, with pain and swelling.** These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- **A strain on the heart or a stroke may occur.**
- **Bleeding may occur.** If bleeding is excessive, you may need to have the blood drained or a blood transfusion.
- **Reaction to the anesthetic may occur**. The most common reactions are nausea and vomiting. In rare cases, death may occur.
- **Infection.** That may require antibiotics or additional surgery.

Risks of this Surgery or Procedure

- **Change in nipple and skin sensation**. Loss of nipple sensation may occur in one or both nipples. This may be permanent.
- **Nipple or skin hyperpigmentation or discoloration.** This may be permanent.
- **Scarring**. All surgical incisions produce scars. Some may require more surgery.
- **Firmness.** Breasts can become too firm. This may require biopsy or more surgery.
- **Delayed healing**. This may require frequent dressing changes or more surgery to remove non-healed tissue.
- **Asymmetry**. Your breasts will be different sizes. You may need more surgery to correct this.
- **Change in breast shape with change in weight after surgery.** This may require additional surgery and may incur additional risk.

- **Allergic reactions to medication given, tape, suture or topical preparation may occur.** Treatment could be required.

- **Obesity** 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 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.

I do not use nicotine products: ___ Yes or ____No; Last used nicotine on: _____

Patient Signature_____Date:_____Time:_____

Alternative Treatments

Other choices:

- Physical therapy to treat pain.
- Wearing undergarments to support large breasts.
- Do nothing. You can decide not to have the procedure.

General Information

- During this procedure, the doctor may need to perform more or necessary 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: **Reduction Mammoplasty.**
- 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.

Provider: This patient may require a type and screen or type and cross prior to surgery. If so, please obtain consent for blood/products.

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: Neck, shoulder, and back pain and rashes beneath breasts.
____ Area(s) of the body that will be affected: Breast.
____ Benefit(s) of the procedure: Decreased breast size and potential improvement of neck, shoulder, and back pain and rashes beneath breasts.
____ Risk(s) of the procedure: Bleeding, scarring, infection and death.
____ Alternative(s) to the procedure: No surgery.

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