BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Blepharoplasty

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

Reason and Purpose of this 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 benefits are worth the risk.

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

Risks of this 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.

- **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.

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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 salespeople and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be taken 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 | ☐ with brow lift ☐ without brow lift** _____

  _____
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with the 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/POA Healthcare**

Reason patient is unable to sign: _____ ☐ Telephone Consent Obtained

First Witness Signature: _____ Second Witness Signature: _____ Date: _____ Time: _____
(One witness signature MUST be from a registered nurse (RN) or provider)

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

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:

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: _____