ABSOLUTE
COSMETIC MEDICINE

BREAST AUGMENTATION CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND.
YOUR AGREEMENT CANNOT BE DISPUTED AT A LATER DATE.

PATIENT'S NAME:_____

1) I authorise ('the Doctor') and his assistants to perform upon me the operation known as Augmentation Mammaplasty.

2) The nature and effects of the operation, the risks and complications involved, as well as alternative methods of treatment, have been fully explained to me by the Doctor and I understand them.

The following points, among others, have been specifically made clear.

	INITIAL
While every attempt will be made to make each breast, including the nipple and the areola, as natural as possible, the objective cannot always be obtained. Exact size at the end of the procedure is not guaranteed.	_____
Breasts may become saggy and require a breast lift which is an additional cost	_____
Although having the breasts match is the surgical objective, perfect symmetry of nipples, areola and breasts cannot always be achieved.	_____
Unfavourable reaction(s) to prescribed medications or anaesthesia can occur. These can include nausea, vomiting, allergic reactions with skin rash, itching, deep vein thrombosis (DVT), ie: clots in legs or lungs.	_____
Bleeding or infection following breast operations may occur and may require additional procedure(s) for treatment. There may be additional costs for this and further investigation. Removal and replacement in 6 months may be required.	_____
Swelling and bruising may take several weeks to disappear, several months are necessary for the breasts to assume their final shape. Sometimes there may be interruption of work and activities leading to financial loss.	_____
Sensation to the breast, including the nipple and areola, may alter and may decrease permanently.	_____
The scars are permanent. Infection and the need for complete removal is possible.	_____
As far as is known, this operation does not influence the later development of breast cancer, although diagnosis could be affected. Lymphoma and breast augmentation illness may possibly be risk factors of breast implants.	_____
There may be a decreased likelihood of satisfactory breast feeding after Augmentation Mammaplasty.	_____
The edges of the implant may be seen or felt due to thin tissues. Sagginess and bottoming out can occur.	_____
Scar formation around the implant can cause rippling or may contract over time making the implant harder and occasionally causing an altered shape (capsular contracture).	_____
Early and late onset of pain needing further investigation or treatment are unexpected and uncommon side effects.	_____
Adjacent structure damage is possible such as nerve damage, vessel or lung injury.	_____
I understand that the practice of medicine and surgery is not an exact science and that the reputable practitioners cannot guarantee results. No guarantee or assurance has been given by the Doctor or anyone else as to the results that may be obtained.	_____

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INITIAL

Any of the above can lead to extra cost and inconvenience. I understand that this is not a Plastic Surgical procedure, but is considered a Cosmetic Surgical procedure. _____

Some of the complications of Augmentation Mammaplasty can cause the need for further surgery. Any re-operation may require an incision under the breast. Some of the complications can cause permanent deformity, unsightly and painful scarring and prolonged illness. Very rarely, some of the complications of any surgery can cause death. Furthermore, there are alternatives to this surgery available to you, such as merely accepting your present status. _____

I understand that the two sides of the human body are not the same and can never be made the same. _____

I will be a compliant, realistic and polite patient I will follow the social media policy and will pay all legal costs associated with the breach of this. _____

I consent to the administration of anaesthetics by the Doctor or under the direction of the Doctor or Anaesthetist, and that side effects including death are possible. _____

I consent to detailed records being kept of the procedure which can be used in any future clinical review (This is a Federal Government Condition of the use of silicone implant). _____

I consent to being photographed before, during and after the treatment. I agree that these photographs become the property of Dr Murray and may be used for medical or educational purposes. _____

I must take my own photos. _____

CONSENT SIGNATURE

I hereby state and acknowledge that I have read and understood the above information on Augmentation Mammaplasty outlining the risks, side effects and complications. I acknowledge that I have also received, read and understood the literature outlining my Rights and Responsibilities at Absolute Cosmetic Medicine. I feel that I have been fully informed and have had all my questions answered.

I agree to follow the instructions given to me by the Clinical Doctors to the best of my ability before, during and after my procedure and to notify them of any problems that may occur immediately, allowing them to manage these for me.

I release all staff from Medicolegal liability claims..

I, _____on ___/____/ ____ consent and agree to the procedure of Augmentation Mammaplasty being performed on myself by the Doctors at Absolute Cosmetic Medicine.

NAME: (Print) _____

SIGNATURE: _____

WITNESS NAME: (Print) _____

WITNESS SIGNATURE: _____

DOCTOR SIGNATURE: _____

I cannot dispute what I have read, agreed to and signed above . If I do then I agree to pay all costs incurred by ACM if I breach this agreement. I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy. I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records. (please initial) _____

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