INFORMED CONSENT FOR
SCAR REVISION

(PLEASE REVIEW AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE)

PATIENT NAME ____

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INFORMED CONSENT-SCAR REVISION SURGERY

INSTRUCTIONS

This is an informed-consent document that has been prepared to help inform you concerning scar revision surgery, its risks, and alternative treatment. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery.

INTRODUCTION

It is impossible to totally remove the presence of a scar, yet plastic surgery may improve the appearance and texture of scars. There are many different techniques of scar revision surgery. Other treatments including non-surgical treatments, and/or physical therapy may be needed in addition to surgery.

ALTERNATIVE TREATMENTS

Alternative forms of treatment include not treating the scar condition, injections of steroid medications into the scar, or the use of special compressive garments/devices worn over the scar. Dermabrasion, laser treatments and other non-surgical and surgical techniques may be used to revise scars. Risks and potential complications are associated with alternative forms of treatment.

RISKS of SCAR REVISION SURGERY

Every surgical procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo a surgical procedure is based on the comparison of the potential risks to benefits. Although the majority of patients do not experience these complications, you should discuss each of them with your plastic surgeon to make sure you understand the risks, potential complications, and consequences of the surgical revision of scars.

It is possible that the scar may be worse after a scar revision and that there may be worse appearance and functional problems than before the revision.

Bleeding - It is possible, though unusual, to experience a bleeding episode during or after surgery. Should bleeding occur, it may require emergency treatment to stop, or drain accumulated blood (hematoma). Do not take any aspirin or anti-inflammatory medications (NSAIDs) for ten days before surgery, as this may contribute to a greater risk of bleeding. Non-prescription "herbs" and dietary supplements can increase the risk of surgical bleeding, and should be stopped (see "Medications to Avoid").

Infection - Infection is unusual after surgery. Should an infection occur, additional treatment including antibiotics or additional surgery may be necessary.

Scarring - All surgery leaves scars, some more visible than others. Although good wound healing after a surgical procedure is expected, abnormal scars may occur both within the skin and the deeper tissues. Scars may be unattractive, raised and a different color than the surrounding skin. Sutures and staples used to close the wound may leave visible marks. There is the possibility that scars may limit motion and function. Additional treatments including surgery may be needed to treat abnormal scarring.

Damage to deeper structures - Deeper structures such as nerves, blood vessels and muscles may be damaged during the course of surgery. The potential for this to occur varies according to where on the body surgery is being performed. Injury to deeper structures may be temporary or permanent.

Wound disruption - Until wound healing is complete, it is possible for the surgical wound to open where the scar revision was performed. Wound disruption can produce a poor surgical result. If this occurs, additional treatment may be necessary.

Deeper sutures - Some surgical techniques use deep sutures. These sutures may be noticed by the patient following surgery. Sutures may spontaneously poke through the skin, be visible, or produce irritation that requires removal or treatment.

Patient compliance - Patient compliance with post-operative activity restrictions is critical. Personal and work activities that involve the potential for re-injury to the scar revision must be avoided until healing is completed.

Allergic reactions - In rare cases, local allergies to tape, suture material, or topical preparations have been reported. Systemic reactions, which are more serious, may result from drugs used during surgery and prescription medications. Allergic reactions may require additional treatment.

Surgical anesthesia - Both local and general anesthesia involve risks. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia or sedation.

Delayed healing - Wound disruption or delayed wound healing is possible. Some areas of the skin may not heal normally and may take a long time to heal. It is even possible to have loss of skin or deeper tissue. This may require frequent dressing changes or further surgery to remove the non-healed tissue.

Smokers have a greater risk of skin loss and wound healing complications.

Unsatisfactory result - There is the possibility of an unsatisfactory result from the surgery to revise scars. Surgery may result in unacceptable visible deformities, loss of function, wound disruption, skin death and loss of sensation. You may be disappointed with the results of surgery.

Death or serious injury – In very rare cases, serious complications such stroke, heart attack or even death have resulted from surgery.

ADDITIONAL SURGERY

In some situations, it may not be possible to achieve optimal revision of scarring with a single surgical procedure. Multiple procedures or treatments may be necessary. Should complications occur, additional surgery or other treatments may be necessary. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with scar revision surgery. Other complications and risks can occur but are even more uncommon. The practice of medicine and surgery is not an exact science. Although good results are expected, there cannot be any guarantee or warranty expressed or implied on the results that may be obtained.

FINANCIAL RESPONSIBILITIES

The cost of surgery involves several charges for the services provided. The total includes fees charged by your doctor, the cost of surgical supplies, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revisionary surgery would also be your responsibility.

DISCLAIMER

Informed consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your plastic surgeon may provide you with additional or different information which is based on all the facts in your particular case and the state of medical knowledge. Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

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

CONSENT FOR SURGERY/ PROCEDURE OR TREATMENT

1. I hereby authorize Dr. Karol Gutowski and/or Dr. Andrea Martin, and such assistants as may be selected, to perform the following procedure or treatment:

   Scar revision surgery

   I have received the following information sheet:

   INFORMED CONSENT - SCAR REVISION SURGERY

2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician(s) and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician(s) at the time the procedure is begun.

3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involves risk and the possibility of complications, injury, and sometimes death.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

5. I consent to the photographing, videographing and televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.

7. I consent to the disposal of any tissue, medical devices or body parts which may be removed.

8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.

9. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE ABOVE TREATMENT OR PROCEDURE 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 TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9).
I AM SATISFIED WITH THE EXPLANATION.

____

Patient or Person Authorized to Sign for Patient

Date________________________ ________________________________Witness

AUTHORIZATION & CONSENT FOR RELEASE OF MEDICAL IMAGES

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Dr. Gutowski and/or Dr. Martin or their representatives.

INTRODUCTION

Medical images (photographs, slides, videos, interviews or any other images of you, or components of your medical record) may be taken before, during, or after a surgical procedure or treatment. These images may be needed to document your medical condition, used as supporting material for authorizing medical coverage and payments, and treatment planning. Consent is required to take, use and release such images. Since Drs. Gutowski and Martin are also educators of other physicians, researchers, and medical writers, your images may be used for other purposes as described below.

1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOGRAPHY

I hereby authorize Dr. Gutowski or Dr. Martin and/or their associates to take any images before, during and after my treatments or surgeries.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOGRAPHY

I hereby authorize Dr. Gutowski and/or Dr. Martin and their associates to use any of these images for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks including the internet, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in supporting documentation for insurance or third-party payer purposes, medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences, and print marketing material (magazine, newspaper, etc) or electronic media (television, internet, etc).

3. CONSENT FOR RELEASE TO PROFESSIONAL ORGANIZATIONS

I further authorize Dr. Gutowski and/or Dr. Martin and their associates to release such images to the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), the American Board of Plastic Surgery (ABPS), the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), and the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS). I provide this authorization as a voluntary contribution in the interests of public education. The images may be used for publication in print, visual or electronic media, specifically including, but not limited to, medical journals (such as *Plastic and Reconstructive Surgery, Annals of Plastic Surgery, Aesthetic Plastic Surgery)*, textbooks, lay publications, patient education or during lectures for the purpose of informing the medical profession or the general public about plastic surgery methods, medical education or examination material by ASPS, ASAPS, ABPS, AAFPRS and ABFPRS. I understand that such images shall become the property of ASPS, ASAPS, ABPS, AAFPRS and ABFPRS and may be retained or released by these organizations for the limited purpose mentioned above. I also grant permission for the use of any of my medical records including illustrations, photographs, video or other imaging records created in my case, for use in examination, certifying and/or re-certifying purposes by ABPS and ABFPRS.

I understand that I will <u>not</u> be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge Dr. Gutowski and/or Dr. Martin
and all parties acting on their authority from all rights that I may have in these images, and from any claims that I have related their use in the above mentioned manner.

I also release Dr. Gutowski and/or Dr. Martin and any employees or agents from all liability, including any claims of libel or invasion of privacy, directly or indirectly connected with, arising out of or resulting from the taking and authorized use of these images or recorded interviews.

I understand that I have the right to request cessation of recording or filming at any time.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient Name ____

Patient Signature ____ Date ______________

Witness or Guardian/Parent______________________________________ Date ______________