FARAHMAND
PLASTIC SURGERY

OPERATIVE CONSENT

Patient:_____Acct#:_____Date:_____

I, hereby authorize Dr. Farahmand, and her associates to perform the following procedure(s) on me:

_____

_____

1. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth above. I, thereby further authorize and request that the above named surgeon and her associates perform such procedures as are in their professional judgment, necessary and desirable. These may include, but not be limited to, procedures involving pathology and radiology. The authority granted under this paragraph shall extend to remedying conditions that are not known to the above doctors at the time the operation is performed.

2. I consent, authorize, and request the administration of such medications and anesthetics as are deemed suitable by my physician (or her associates under her direction). I recognize that when sedation and intravenous medication are used, they present additional risks and I have discussed those risks with Dr. Farahmand.

3. I recognize that when general anesthesia is used, it may present additional risks over which the above doctor has no control. I agree to discuss the risks of the general anesthesia with the anesthesiologist/nurse anesthetist before surgery is performed.

4. I am aware that the practices of medicine and surgery are not exact sciences, and **"I ACKNOWLEDGE THAT NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME AS TO THE RESULTS OF THE OPERATION OR PROCEDURE(S)."**

5. I agree to be photographed before, during, and after the treatment; that these photographs shall be the property of the above named doctor; and they are intended for study and teaching purposes.

6. I agree to keep the above named doctor informed of any change of address so that he may notify me of any late findings, and I agree to cooperate with the above named doctor in my care after surgery until completely discharged.

Audrey Farahmand MD, Plastic and Reconstructive Surgeon
12411 Brantley Commons Court, Fort Myers, FL 33907
Phone (239) 332-2388 Fax (239) 332-2382
www.farahmandplasticsurgery.

X_____
Initial

7. I consent to disposal by Dr. Farahmand or her associates of any tissue or parts which might be removed.

8. I am not known to be allergic to anything except;
(list):_____.

9. This procedure has been personally explained to me by Dr. Farahmand and I completely understand the nature, purpose, alternatives, consequences, and risks of the procedure(s). The following points, among others, have been specifically made clear and I understand that in regard to:

A. **SCARRING**: The incision will heal, with a scar which may be permanent and might be larger or more noticeable than desired. Additional surgery or treatments might be necessary to improve its appearance.

B. **BLEEDING**: Postoperative bleeding or complications (such as clots) may occur, requiring a second operation.

C. **INFECTION**: There is a possibility that infection could occur.

D. **CHANGE IN SENSATION**: Numbness or hypersensitivity may occur within and around the surgical area.

E. **REJECTION OF SUTURE MATERIAL**

F. **SEPARATION**: Separation or opening of the wound is possible for several reasons and may require additional surgical procedures.

G. **CHANGES IN PIGMENTATION**:
The final scar may be the same color, lighter than, or darker than the surrounding tissues.

H _____
I _____
J_____

I have read the above consent, and fully understand its contents. I authorize the above named doctor and his associates to perform the surgical procedure(s) on me.

DATE: _____ SIGNATURE: _____

DATE:_____ WITNESS: _____

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