**MARK BROUDO M.D. P.A.**
**1100 SW 57 AVENUE**
**SUITE 100**
**MIAMI, FL 33144**

## CONSENT TO BREAST AUGMENTATION / MASTOPEXY

**PATIENT:**_________________________ **DATE:**_____________________

**TIME:**_____________________________

1. I hereby authorize Dr. Mark Broudo to perform a surgical operation for increasing the size and shape of my breasts, known as Breast Augmentation Mammoplasty and/or Mastopexy, on:

_______________________________________________________________________________
(Name of Patient)

2. The procedure listed in Paragraph 1 has been personally explained to me by the above doctor and I completely understand the nature and consequences of the procedure. The following points, among others, have been specifically made clear:

   a. The operation has been done for several years, but the end results are not, and cannot be determined, for a number of years to come.
   b. Research indicates that the material implanted in the body does not cause malignancy in human subjects. However, when having a mammogram, you must inform the technician that you have implants. The implant could interfere with finding breast cancer during mammography
   c. There is a possibility that my body may not tolerate these implants, making it necessary to remove the implants. This occurs in a small percentage of cases.
   d. A cyst may form in the area adjacent to the implants, causing fluid accumulation which may require drainage by needle or removal of the implants.
   e. The breasts can become firm (capsule formation and contracture). This condition can be permanent and can cause pain, hardness, and change in shape and may require further surgery.
   f. No guarantee has been given as to size and shape of the breasts. Good results are expected, but not guaranteed.
   g. In some patients the margin of the implants can be felt.
   h. The incisions will heal with a scar which will be permanent.
   i. Postoperative bleeding may occur requiring a second operation for its removal.
   j. After being exposed to cold temperature (i.e. swimming in cold water), the breasts may feel cooler than surrounding body tissues.
   k. Pregnancy is not recommended for at least six (6) months after the surgery.
   l. Numbness or hypersensitivity of the breast and nipple may be experienced following surgery.
   m. The procedure is subject to the same post-operative complications as other surgical procedures.
   n. There may be swelling and discoloration (black and blue marks) which can persist for several weeks.
   o. Infection is possible in any type of surgery.
   p. Partial or complete loss of nipple and/or areola can occur following surgery.
   q. The implant shell may break at some point in the life of the implant or during the duration it is implanted. Whenever a saline-filled implant does deflate, it usually happens quickly and requires surgery to remove and, if desired, replace the ruptured implant. Since salt water is naturally

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present in the body, the leaked saline from the implant will be absorbed by the body instead of being treated as foreign matter.

3. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore further authorize and request that the above-named surgeon, his assistants, or his designees perform such procedures as are, in his professional judgement, necessary and desirable, including, but not limited to, procedures involving pathology and radiology. The authority granted under this Paragraph 3 shall extend to remedying conditions that are not known to the above doctor at the time the operation is commenced.

4. I consent to the administration of local anesthesia to be applied by or under the direction and supervision of the above doctor, with the exception of:

   ______________________________________________________________

5. I recognize that when general anesthesia is used it presents additional risks over which the above doctor has no control and I agree to discuss the risks of general anesthesia with the anesthesiologist before surgery is performed.

6. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure.

7. I consent to be photographed before, during, and after the treatment; that these photographs shall be the property of the above doctor and may be published in scientific journals and/or shown for scientific reasons.

8. If in the event a complication should arise that would necessitate returning to surgery, the patient will be solely responsible for the hospital fee.

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

10. I am not known to be allergic to anything except:____________________________________

**I HAVE READ THE ABOVE CONSENT AND RECEIVED A COPY OF IT. I FULLY UNDERSTAND THE CONTENTS OF THE CONSENT AND AUTHORIZE AND REQUEST THE ABOVE DOCTOR TO PERFORM THIS SURGICAL PROCEDURE ON ME.**

| ______________________________ | ______________________________ |
| --- | --- |
| Witness | Patient |

______________________________

Date

Patient Initials_______