



# CONSENT FORM FOR BREAST REDUCTION

Med Rec. No.....

Surname:.....

Forename: .....

DOB:.....

AFFIX LABEL HERE

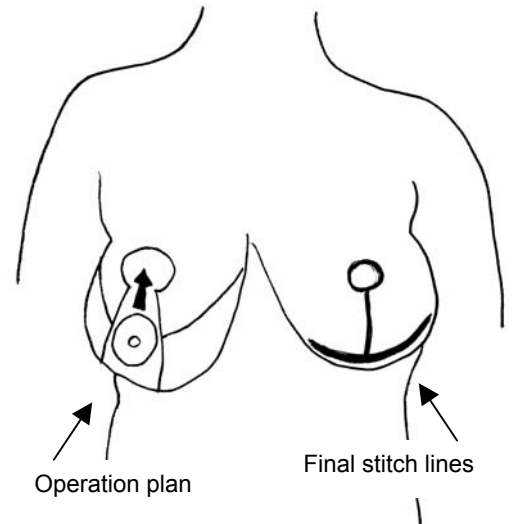
### PROPOSED TREATMENT

The doctor has explained that I, *(name of patient)* .....  
have requested **breast reduction** on .....side/s.

**This means removing some fat, glandular tissue and skin to reduce the size of one or both breasts. Some of the areola (the brown skin around the nipple) is also removed.**

Under a general anaesthetic, a cut is made around the nipple. Excess tissue is removed and the nipple and areola moved into their new position. Skin from both sides of the breast is then brought down around the areola to reshape the breast. Excess fat may also be removed from around the armpit. Any bleeding is stopped and the wounds closed. One or more small plastic tube drains may be left in the wound temporarily to reduce any fluid collections.

Usually the areola and nipple can be re-located without cutting their nerve and blood supply, but in some very large breasts, this area must be removed and re-attached (with a loss of sensation afterwards).



### RISKS

*These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your plastic surgeon if you have any general or specific concerns.*

I understand there are risks associated with any **anaesthetic** (see separate Anaesthetic Consent Form).

I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand the procedure has the following **specific risks and limitations**:

- I may have some bleeding, but this is usually easily controlled during the operation.
- I may have some shooting pains in the breast afterwards that may persist for some months.
- The sensation of my breast/s and/or nipples will be reduced for some months after the operation as a result of the tissue swelling. In most cases this will improve with time, but may occasionally remain.
- My wounds may become infected, with redness, swelling and discharge. I may need antibiotics to treat this.
- Fat necrosis (decomposition of some fat cells) may occur. This may be accompanied by a discharge but a discharge does not necessarily mean the wound is infected.
- The size and symmetry of my breasts afterwards cannot be predicted.
- Afterwards, if I have a baby, I may not be able to breastfeed.
- I will have some permanent scars around my breasts, which will fade with time. In a few unpredictable cases, the scars may remain red and excess scar tissue may be laid down.

I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

### INDIVIDUAL RISKS

I understand the following are possible significant **risks and complications specific to my individual circumstances**, that I have considered in deciding to have this operation:

.....  
.....

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FOR  
BREAST REDUCTION**

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**DECLARATION BY PATIENT**

- I acknowledge the plastic surgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the surgeon any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my plastic surgeon during this operation.
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I understand that a doctor other than the specialist plastic surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If a needlestick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.

Signature of patient \_\_\_\_\_ Date \_\_\_\_\_

*If the patient is an adult and unable to give consent, a proxy form must be completed and attached*

**DECLARATION BY DOCTOR**

- I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature \_\_\_\_\_

Doctor's name \_\_\_\_\_ Date \_\_\_\_\_  
*(please print)*

**INTERPRETER'S DECLARATION** - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's signature \_\_\_\_\_ Date \_\_\_\_\_

Interpreter's name \_\_\_\_\_  
*(please print)*