CONSENT FOR LIP AUGMENTATION WITH SILICONE IMPLANTS(S)

I, ______________________________ hereby request and authorize Dr. Mauricio Giraldo to perform upon me a surgical operation known as a lip augmentation with a solid silicone implant. A shaped soft, flexible, sterile, medical-grade, custom fit silicone implant is used for augmentation of the lips. The implant is FDA approved for the face, but it will be used of the lips, i.e. an “off label” use. Off label use permits a physician to use a material that is FDA approved for purpose that is not specifically FDA approved.

This procedure has been explained to me, and I completely understand the nature and consequences of the procedure. The purpose of the procedure is to increase the fullness of the lip(s) by making a small incision in each corner of the mouth; Dr. Giraldo makes a tunnel through the lip(s), extending from one side to the other, into which the implant is inserted.

I understand that in addition to the general complications of surgery, such as death, hematoma, pneumonia, heart attack, stroke, bleeding, and blood clots in the leg veins rising up to and damaging the lungs, there may also be complications specific to this procedure. Complications from this/these procedure(s) may include but are not limited to:

- Dissatisfaction with symmetry, size, and shape of the lips. Wrinkling and rippling of implants is unusual but possible. With thin skin and little subcutaneous tissue, these wrinkles can show through.
- Abnormal contour of the lip(s), extrusion (implant breaks through sutures), visible edge of implant, or shifting of implant.
- Swelling for an indeterminate period. Much of the swelling will normally disappear in 2-3 weeks and the remainder may require several months.
- Bruising may persist for 1-2 weeks.
- Nerves are stretched out and persistent numbness, burning, or tingling can occur. Damage of the nerves can cause temporary or persistent lip and jaw pain. In rare occasions, permanent areas of numbness may persist.
- Allergic or other unfavorable reactions to one or more of the substances used in the operation.
- The life span of an implant is not known, and ultimately, all implants will fail. Since there is no fill or gel a broken implant would only need to be changed if there was a visible change. Fees for replacement will be my responsibility.
- Scar tissue normally forms around all implants. Occasionally, capsule contracts cause unusual firmness of the lip. The contracted capsule can become painful and calcium deposits may form on the capsule. If so, additional surgery is recommended to improve the results.
- Implant placement is along the upper edge of the lip; it can become displaced or infected early on.
- I understand that silicone implants have been in use for more than 30 years, but the actual life span of the implant is unknown. The actual fate of the silicone and silicone breakdown products is unknown and could persist even after the implants were removed.
- It is not known if implants will have any genetic effects on the developing fetus or affect the nursing infant through the milk.
- The future removal of my implants will not return my lip to their present condition. There might be psychological depression about my stretched skin.

For women of child bearing age: To the best of my knowledge, I am not currently pregnant. Since anesthesia can be harmful to the fetus, if there is a chance I might be pregnant at the time of surgery, it is my responsibility to inform Dr. Giraldo.

It must be recognized that medicine and surgery are not exact sciences. I understand there is no guarantee of results of any treatment.

Rewrite the following: “I understand that the practice of medicine is not an exact science and although good results are expected, there can be no guarantee as to the results.”

“I will not drive while on narcotic pain medications or sedative drugs prescribed by my cosmetic surgeon.”

I acknowledge and give consent to pre-operative and post-operative digital photography. This digital photography may be used for the purpose of patient chart documentation, scientific presentations, patient awareness and education, or digital photography on the website of Medilaser, Cosmetic Surgery and Vein Center.

I understand the regular charge applies to all subsequent treatments. In some situations, it may be possible to I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

I have read the above request and fully understand it. I acknowledge that I have been advised as to alternative methods of treatment, have been given an opportunity to ask all questions regarding the treatment to be administered and am satisfied that I have been fully informed and understand the procedures.

Patient Signature ______________________________ Date / / 
Witness ______________________________ Date / / 

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