Consent form for liposuction

I…….....……hereby authorize Dr…….....……. on date ……and ……..time ……..AM/PM to perform liposuction o my ……..I fully understand the applications and the possible results of this procedure. I have read and understood the details of the drugs used-their effects and side effects, the postoperative events and results.

I ……..understand that local anesthesia is much safer then general anesthesia. I consent to the administration of oral sedation and the local infiltration of anesthesia by Dr…….....……and the designated heath professional ……..... I understand that there are risks associated with anesthetic drugs given locally or intravenously, such as allergic or toxic reactions.

Dr. …….....…….has discussed in details with me the entire surgical procedure currently known as liposuction or suction lipolysis or suction lipectomy, including possible risks, untoward side effects and results. I have also read other literature concerning this procedure and Dr…….....….....……..has answered all my questions to my satisfaction I believe that I have adequate knowledge on which to base my informed consent to the liposuction.

I also understand that it takes 3-6 months for the full results of the surgery to be seen. I also have been told that approximately ….....… liters of fat will be removed. K also understand that liposuction is not a procedure to reduce weight, but to improve the shape and contours of the body.

correct “cellulite” and other forms of skin surface dimpling and wrinkling. Stretch marks also can not be corrected by surgery. I understand that this procedure does not

I understand that liposuction is a cosmetic procedure and that a full guarantee as to the final results that may be obtained and for the ultimate appearance that is produced, can not be assured.

I understand that 100% results cannot be obtained and I may need a second procedure.

There may be initial temporary lumpiness and swelling of the area and of dependent parts which resolve in due course. Like any surgery, liposuction may be associated with untoward side effects. They include bruising lumpiness, dimpling, sagging of the skin, scarring, numbness, tingling or persistent soreness, minor depression, swelling of the legs and infection of the skin.

A second operation requiring skin excision and removal may be necessary. I also understand that during the course of the above operation, unforeseen conditions may necessitate additional or different procedures than those originally planned.

I therefore authorize Dr. ……..…… to perform or arrange to perform such procedures deemed necessary according to his/her. Professional judgment.

I impose no specific limitations or prohibitions on Dr ……..... regarding this surgery and authorize him/her to perform liposuction on my…….....…….....

Name and signature of patient/- Name and signature of doctor /-

Name and signature witness /-

You have been scheduled for liposuction of the ……..……. to be done on .....……. at …….to …….AM/PM.

Liposuction is “body contouring technique,” It is a means of reducing localized fat deposits that are difficult r impossible to remove by diet of exercise. It is not a technique for treating obesity or “cellulite”.

Liposuction is a surgical operation that can be performed under local or general anesthesia. We perform liposuction under local anesthesia which necessitates the injection of a solution under the skin and into the fatty tissue before it is removed. Oral and occasionally intravenous sedation and fluid replacement may be necessary during the operation. After anesthesia is completed, a ling narrow hollow metal tube is placed through the skin into the fatty area to be treated. This hollow metal tube is connected to a suction machine which will then be used to suck out the unwanted fat. At the completion of the operation, a padding and compression garment is worm for support and compression. Patients need to come for dressing for 2-3 days and usually return to work after 3-4 days.

Please be sure that you have read and thoroughly understood the pre-and postoperative instructions.

Have you had any surgery before? Yes/no

Have you had local anesthesia before? Yes/no

Did you have tooth extraction before? Yes/no

Did you have any injury / wound, that was sutured? Yes/no

Did you have any problem with bleeding?	Yes/no
Did you have stomach acidity problem?	Yes/no
Do you smoke? If so, how much?	Yes/no
Do you drink excessive amounts of tea / coffee?	Yes/no
Do you have diabetes / asthma / any other disease?	Yes/no
Have you taken injection tetanus toxoid in the last six months?	Yes/no
Do you faint when seeing blood? Are you nervous person?	Yes/no
Have you received pre-, postop instruction sheets?	Yes/no

Patient's signature /- Doctor's signature /-

Patient's name ……..…… Doctor's name ……..…….....

Date : ……

Patient's Address ……

…….....

Permanent Address (if different) ……

…… …….....

Landline Number : ……

Moblie : ……..