AREOLA REDUCTION CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

I _____

Printed Name

hereby give my informed consent to undergo the surgical procedure of Areola Reduction under the care of Dr Murray at Absolute Cosmetic Medicine.

I have read and fully understand the following possible risks and complications of the procedure, and I acknowledge that I have had the opportunity to discuss any concerns or questions I may have had with Dr Murray and his team.

	Patient Initial
• Infection or allergic reactions	_____
• Scarring	_____
• Granulomas (allergic lumps)	_____
• Spitting of sutures	_____
• Lumps	_____
• Asymmetry (left side not equal to right)	_____
• Nipple and areola necrosis (skin death)	_____
• Damage to nerves, blood vessels, skin, and surrounding structures	_____
• Bleeding	_____
• Septicaemia (blood poisoning)	_____
• Pain (acute or chronic)	_____
• Redness	_____
• Swelling	_____
• Variable results	_____
• Clots in legs and/or lungs, or death	_____
• Psychological disturbance, anxiety, depression, and stress	_____
• Loss of work time and income	_____
• Interference with breastfeeding	_____
• Anaesthetic or sedation reactions	_____
• Medication risks, including anaphylaxis	_____
• Failure and need for revision surgery	_____
• Further costs	_____

_____

Patient Full Name

_____ _____

Patient Signature *Date*

_____

Witness Full Name

_____ _____

Witness Signature *Date*

PH: 9389 9099 | F: 9389 9390 | reception@absolutecosmetic.com.au | www.absolutecosmetic.com.au
Image 21, Suite 2, 21 Stirling Highway, Nedlands, WA 6009

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- I agree to follow all preoperative instructions, including cessation of smoking.
- I understand that upon discharge, my carer will take responsibility for my general care and supervise me closely, including staying with me overnight, driving and important decisions for the first 24 hours.
- I agree to report any physical or psychological concerns immediately and allow Dr Murray to manage any related to my procedure.
- I release Dr Murray and his team from medico-legal liability.
- I have been offered a copy of this document.

I acknowledge that the risks and complications associated with this procedure have been explained to me, and I have been given the opportunity to ask questions and receive answers to my satisfaction. I understand that no guarantees have been made regarding the results of the procedure, and I agree to accept the risks and complications associated with the procedure. I hereby consent to the Areola Reduction procedure with Dr Murray at Absolute Cosmetic Medicine.

_____

Patient Full Name

_____ _____

Patient Signature *Date*

_____

Witness Full Name

_____ _____

Witness Signature *Date*

I also acknowledge that photographs may be taken for clinical use only, and I understand that I am responsible for taking my own photographs for my records.

I agree to follow the Absolute Cosmetic Medicine social media policy, and I understand that any breach of this policy may result in further costs being incurred by me.

I acknowledge that I have read, understood, and agreed to the above information, and I cannot dispute what I have read, agreed to, and signed above. If I breach this agreement, I agree to pay all costs incurred by Absolute Cosmetic Medicine.

_____

Patient's Initial

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