BREAST RECONSTRUCTION WITH LATISSIMUS MUSCLE FLAP

In breast reconstruction with the latissimus dorsi, a muscle located on the back, along with its attached skin is transferred to the chest region for the breast reconstruction procedure. In some cases, an implant may be attached underneath the muscle flap to give the breast mound additional projection. If it is determined and agreed that an implant should be used, an additional and separate consent for the implant must be used.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform breast reconstruction with latissimus muscle flap on _____.
(patient name)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient's Initials

_____ The details of the procedure have been explained to me in terms I understand.
_____ Alternative methods and their benefits and disadvantages have been explained to me.
_____ I understand and accept possible risks and complications include but are not limited to:

- *Bleeding*
- *Infection*
- *Change in skin sensation*
- *Scarring*
- *Weakness of arm and shoulder movement*
- *Delayed healing and loss of flap*
- *Fat necrosis*
- *Seroma requiring draining*
- *Inability to breast feed*
- *Excessive firmness due to internal scarring*
- *Unsatisfactory result*

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with any surgical procedure.
_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring, but cannot control its ultimate appearance.
_____ I understand that significant scars, both on the donor flap area on the back and around the reconstructed breast, cannot be avoided.
_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.
_____ I have informed the doctor of all my known allergies.
_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and any other.
_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
_____ I have been advised that I should avoid taking any aspirin, aspirin containing products or anti-inflammatory medications for ten days prior to surgery to help reduce the risk of bleeding.
_____ I am aware and accept that no guarantees about the results of the procedure have been made.
_____ I have been informed of what to expect post-operatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

Continued

____ Pre- and post-operative photos and/or videos will be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending physician.

____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____ _____

Patient Signature / Date Witness Signature / Date

_____ _____

Print Patient Name Print Witness Name

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

_____

Physician Signature / Date

_____ copy given to patient _____ original placed in chart

initial initial