INFORMED CONSENT FORM

Breast Reduction (Reduction Mammaplasty)

This draft supports, but does not replace, an in-person discussion with the surgeon. Do not sign until the individualized procedure plan and risks have been completed.

PATIENT AND PROCEDURE DETAILS

Full name: _____

Date of birth: _____

Patient / file number: _____

Counseling date: _____

Facility / place of surgery: _____

Proposed procedure, side and area: _____

Procedure overview

Breast reduction removes excess breast skin, fat and glandular tissue to reduce breast weight and size. The nipple is repositioned; technique, expected resection volume and pathology testing should be discussed.

Purpose and potential benefits

The goal is relief of breast-related neck, back or shoulder symptoms and improved proportion; full symptom relief is not guaranteed.

Alternatives

No surgery; supportive garments, physiotherapy or symptom-directed conservative care.

Procedure-specific risks

Bleeding, infection, wound separation, delayed healing, permanent or widened scars, fat necrosis, asymmetry, under- or over-reduction, altered sensation, impact on breastfeeding; rarely loss of nipple–areola blood supply or tissue and further surgery. Pathology findings can prompt further investigations.

Postoperative care

Follow bra, wound and activity guidance. Seek urgent care for nipple color change or rapidly increasing one-sided swelling.

Questions for your surgeon

How much tissue is expected to be removed? Will the tissue be sent for pathology?

General surgical and anesthesia risks

Any operation can involve bleeding, hematoma, infection, delayed healing, wound separation, scarring, pain, numbness, swelling, allergy or medication reactions, venous blood clots (DVT or pulmonary embolism), anesthesia-related complications and, rarely, life-threatening events. Individual risks vary with health status and procedure.

Personal factors affecting risk

Tell the surgeon about smoking/nicotine use, diabetes, high blood pressure, cardiac or lung conditions, previous operations, bleeding or clotting disorders, poor wound healing, possible pregnancy, prescribed medicines, hormones, supplements and allergies. Do not stop prescribed medications without medical advice.

Expectations, additional treatment and costs

Cosmetic outcomes are personal and subjective. Asymmetry, persistent scars, dissatisfaction or unexpected healing may require additional care or revision. Timing, feasibility, likely benefit and potential additional costs of revision must be discussed separately.

Recovery and warning signs

Attend follow-up appointments. Seek prompt care for fever, worsening redness, pus, increasing bleeding, uncontrolled pain, sudden shortness of breath, chest pain or new swelling of one leg. Procedure-specific emergency warning signs are described above.

Alternatives and right to decline

You may decline the proposed operation, obtain a second opinion and withdraw consent before the intervention begins. Declining elective cosmetic surgery usually means retaining the current appearance; functional concerns should be assessed separately.

Photographs and privacy

Clinical photographs and medical records needed for care must be handled under applicable health-data confidentiality rules. Educational, social media, advertising or other public use is NOT authorized by this surgical consent and requires separate explicit permission.

INDIVIDUALIZED PLAN AND RISK NOTES (TO BE COMPLETED BY SURGEON)

Incisions, technique, side and additional procedures: _____

_____

Relevant conditions / risks / allergies / medications: _____

_____

Anesthesia and estimated duration: _____

_____

PATIENT COUNSELING AND DECISION RECORD

The purpose, technique, reasonable alternatives, consequences of declining surgery, significant risks, expected recovery and emergency warning signs were explained to me in a language I understand. I could ask questions and seek another opinion. I understand that outcomes are not guaranteed and additional care or revision may be needed. I know I can withdraw my consent before the procedure begins.

[ ] I consent to the procedure individualized and explained above.

[ ] I decline the proposed procedure / defer my decision.

Patient printed name and signature: _____

Date / Time: _____

Counseling surgeon name and signature: _____

Date / Time: _____

Legal representative, relationship and signature (if applicable):

_____

Date / Time: _____

Interpreter name, language and signature (if applicable): _____

Date / Time: _____

DRAFT • Requires surgeon and legal review • Not approved for clinical use