INFORMED CONSENT FORM

Abdominoplasty (Tummy Tuck)

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

Abdominoplasty removes excess abdominal skin and sometimes fat, corrects abdominal wall laxity and may reposition the navel. Any fascial repair or additional liposuction must be discussed separately.

Purpose and potential benefits

It aims to improve abdominal contour and reduce skin excess; it is not a weight-loss procedure and results cannot be guaranteed.

Alternatives

No surgery; weight management, exercise, or more limited operations where appropriate.

Procedure-specific risks

Bleeding, seroma, infection, wound breakdown, skin or umbilical ischemia/necrosis, long or thick scars, asymmetry, persistent numbness, contour irregularity, blood clots and pulmonary embolism; rarely internal injury or reoperation. Smoking, diabetes, obesity and combined procedures can elevate risks.

Postoperative care

Follow guidance on safe early walking, compression and drains. Breathlessness, chest pain, one-sided leg swelling or sudden increasing pain require emergency evaluation.

Questions for your surgeon

Will rectus diastasis be repaired? What is my clot-prevention plan?

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