

PATIENT ADVISORY AND INFORMED CONSENT FOR ENDOSCOPIC ASSISTED DEEP PLANE BROW LIFTING

I hereby request and authorize Dr. Rotter to perform a surgical procedure known as endoscopic assisted deep plane brow lift. The intent of the operation is to improve the appearance of the forehead, upper eyelids, and eyebrows.

Although complications occur, these are extremely low. However, possible complications for brow lifting are as follows:

- I. NERVE DAMAGE:** Nerve damage can cause **loss of sensation** and/or **affect movement of your eyebrows, and eyelids.** (Initials)_____
- Such occurrences could include:*
- ° **Crooked eyebrows or inability to show emotion on forehead** from poor movement of the forehead. (Initials)_____
 - ° **Inability to move the eyebrows or eyelids** could lead to severely dry eyes and inability to blink, which can cause **blindness or unsatisfactory appearance.** (Initials)_____
 - ° **Inability** to move the shoulder. (Initials)_____
 - ° **Numbness** may be noted around the ears, cheeks, and incision areas. (Initials)_____
 - ° **Nerve damage and numbness** usually have full recovery within twelve months. However, any nerve loss that persists more than one-year will most likely be permanent. (Initials)_____
- II. SCARRING:** This procedure will result in some scarring. Dr. Rotter will make every reasonable effort to make these scars as inconspicuous as possible. The coronal incisions will result in some numbness and itching of the scalp that may slowly resolve over several months. There will be permanent scars across the top of the scalp or at the hairline, which can be covered by hair. (Initials)_____
- III. ASYMMETRY:** Most people are not perfectly symmetric before surgery. Therefore absolute symmetry cannot be expected. (Initials)_____
- IV. NECROSIS:** Necrosis is the loss of skin. This rarely occurs but could involve the forehead, scalp, and incision sites. Sometimes caused by a hematoma (a collection of blood or fluid that may accumulate in the operative sites which may require aspiration, drainage, or removal by surgery). This risk increases with high blood pressure or intake of aspirin and like medications and/or use of tobacco products. Necrosis will lead to **scarring and hair loss.** (Initials)_____
- V. HAIR LOSS:** Hair loss and hairline changes can result from incisions and scarring that could be temporary to permanent. The loss becomes evident 1 to 2 weeks after surgery and many months are needed for regrowth. (Initials)_____
- VI. PAIN:** You should have minimal discomfort. The treated areas may “burn” or “sting” for the first 2 or 3 days. Tylenol® or other acetaminophen pain reliever should be all that you need. If stronger medicine is needed, please call Dr. Rotter. **ONLY TAKE ASPIRIN, MOTRIN®, ADVIL® OR SIMILAR PAIN RELIEVERS** under Dr. Rotter’s direction! (Initials)_____
- VII. INFECTION:** The involved area could range from the incision sites out to the entire surgical area. The appropriate treatment can require changes in medications, possibly hospitalization and rarely surgery. (Initials)_____

SOME OTHER COMPLICATIONS INCLUDE:

- **Excessive bruising and swelling.** (Initials)_____
- **Lumpiness, dimpling, minor depressions and irregularities under the skin** usually resolve over a few months.
If they do not resolve, a minor revision may be required. (Initials)_____
- **Hyperpigmentation** (darkening of skin). (Initials)_____

THE FOLLOWING POINTS HAVE ALSO BEEN SPECIFICALLY MADE CLEAR:

- ◆ I realize much depends on how well I comply with pre- and postoperative instruction and my body’s ability to heal. I understand that **poor healing of the skin** is usually associated with **cigarette smoking** and **diabetes**. (Initials)_____
 - ◆ There, of course, are scars as a result of this surgery and these scars are permanent. Every effort will be made to conceal them or to make them as inconspicuous as possible. On occasion, a thickening or spreading of a scar may develop requiring surgical revision. (Initials)_____
 - ◆ I authorize Steven M. Rotter, MD and assistants to perform any other procedure, which he may deem necessary or desirable in the course of the procedure to improve the outcome or for any unforeseen condition. (Initials)_____
 - ◆ I consent to the administration of anesthesia to be applied by or under the direction and supervision of Dr. Rotter or such anesthetists selected and the use of such anesthetics, as they may deem advisable. I understand that rarely adverse reactions to anesthetic drugs may occur. (Initials)_____
 - ◆ I am aware that the practice of medicine is not an exact science, and I acknowledge that no expressed or implied guarantees or warranty has been made to me as to the results of this operation. (Initials)_____
 - ◆ I agree to keep Dr. Rotter informed of any change of address so that he can notify me of any late findings, and I agree to cooperate with Dr. Rotter in my care after surgery until completely discharged. (Initials)_____
 - ◆ I have read the above consent and fully understand it. I fully understand the nature of the surgery. I acknowledge that I have been advised to the alternative methods of treatment and have been given an opportunity to ask all the questions regarding the procedure. (Initials)_____
- *** Since **frown lines** can rarely be permanently erased, some milder residual frown lines are likely. No forehead lift surgery completely erases those. They require direct and different treatment such as Botox, chemical peeling, direct excision, fat grafting, collagen injection, etc. (Initials)_____
- *** It is unknown at the present time how long the results of a deep plane forehead lift will last. It is not unlikely that you will notice some reappearance of wrinkles and frown lines as you continue to age. You will also likely notice some lowering of the level of the eyebrows, as you grow older. (Initials)_____

ANY COMPLICATIONS OR DISSATISFACTION MAY REQUIRE A SECOND SURGERY, PROCEDURE, AND/ OR MEDICATIONS IN THE FUTURE.

In the box provided, please write in your own handwriting the following sentences:

“All my questions have been answered.
I understand the nature and all risks of the surgery.”

◆◆◆ I am satisfied that I have been fully informed. I request and authorize Dr. Rotter to perform this surgical procedure on me. ◆◆◆

SIGNATURE: _____

DATE: _____

WITNESS: _____

DATE: _____