ADVANCE COSMETIC AND LASER CENTER
Dr. Tim Roham
629 Camino De Los Mares
Suite l03, San Clemente CA.92673

CONSENT FORM FOR SUCTION LIPOLYSIS WITH AUTOLOGOUS FAT TRANSFER

1) I hereby request the above named surgeon (s) and /or their associates to perform a surgical procedure known as suction lipolysis and injection of autologous fat.

2) I understand that every surgical procedure involves certain risks and possibilities of complications such as Potential short-term and long-term complications include
*Postoperative swelling
*Infection,
*Scarring at the port incision sites,
*Necrosis of the skin,
*Underlying soft tissue irregularities resulting in unsatisfactory final contour,
*Nerve injury resulting in temporary or permanent weakness.
*Bleeding,
*Irregularities of skin,
*Pigmentation changes (lighter or darker),
*Varicose or spider veins necrosis of skin
These and other complications may follow even when the surgeon uses the utmost care, judgment and skill. This is a relatively new procedure and the long-term results are unknown. These risks have been explained to me and I accept them.

3) The healing of any wound is with scar tissue, and I understand that scars require a year's time to look their best but, in fact are permanent.

4) I have an understanding of the operation which includes but is not limited to the above items. I understand that a secondary revision may be required in some cases. I also understand that charges will be made for the use of the operating room, whether in the office or in the hospital, and for any materials required. I agree to be responsible for these charges.

5) I consent to the administration of local or general anesthetic agents by or under the direction and supervision of the above doctor (s), anesthetist, or nurse working with them.

6) I understand that if necessary, I will be in a surgical dressing for approximately one week. Upon my return visit, I will wear a support girdle or support dressing for one month if necessary.

7) I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure; nor are there any guarantees against unfavorable results.

8) I consent to be photographed before, during and after the surgery; that these photographs shall be the property of the above doctors and may be used as they deem proper for scientific and educational purposes.

9) I agree to keep the above doctor (s) informed of any change of address, and I agree to cooperate with them in my care and surgery until completely discharged.

10) I understand that the doctor's fees are separate from the anesthesia and hospital charges, and implant costs and the doctor's fees are agreeable to me. There may be a fee if a secondary procedure is required. Personal expectations vary; please ensure that you have spoken with your doctor and he has understood your expectations of surgery. Some operations require secondary or multiple procedures to obtain a better result.

11) I have read a copy of the foregoing consent for the operation, understand it, accept these facts and hereby authorize the above doctors to perform this surgical procedure on me. I am aware that after suction lipolysis there will be bruising and swelling which take weeks or months to resolve. Occasionally, the skin becomes wrinkled or pitted and cellulite may look worse. The skin could have a corrugated look.

I realize after fat injection that the product may not last a long time and could dissolve leaving the original defect. Part of the product may dissolve and a repeat injection may be necessary. The fat could appear calcified in a later x-ray of the area of fat injection.

Patients Name (Please Print) _____Date_____

Patients Signature _____

I understand and acknowledge that all fees paid to Dr. Roham are non-refundable and I agree to these terms and I will not receive a refund or chargeback.
Patients Initials

IF THE PATIENT IS A MINOR, COMPLETE THE FOLLOWING
The Patient is a minor and is _____ years of age; and we, the undersigned, are the parents or legal guardians of the patient and do hereby consent for the patient to have treatment.
Parent or Legal Guardian _____

Witness _____

PHYSICIAN SIGNATURE_____DATE_____

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Fat Transfer

The following list represents a partial review of the complications, potential complications and sequelae, which have been discussed with me, in consideration of my forthcoming Fat Transfer procedure with Dr. Tim Roham. While Dr. will make every effort to contour symmetrically there are no absolute guarantees in this procedure and unevenness or lumpiness may occur.

LIST OF POSSIBLE COMPLICATIONS

	Patients Initials
1. Bleeding	1._____
2. Infection	2._____
3. Anesthetic Reaction	3._____
4. Swelling	4._____
5. Pain	5._____
6. Ecchymosis (Bruising)	6._____
7. Irregular Contour	7._____
8. Indurations (hardening beneath the skin)	8._____
9. Dimpling	9._____
10. Lumpiness	10._____
11. Unevenness	11._____

_____ _____

PATIENTS NAME DATE

PHYSICIAN SIGNATURE_____

POST OPERATIVE FAT TRANSFER-INSTRUCTIONS

IMMEDIATELY AFTER SURGERY

. Rest at home for a few days following surgery. Short walks are permitted and encouraged the day after the surgery. Stay in the company of a responsible adult.

. **TOO MUCH ACTIVITY IN THE IMMEDIATE POST-OPERATIVE PERIOD WILL RESULT IN EXCESSIVE SWELLING AND POSSIBLE BLEEDING**

. You will wear a stretch support garment or bandage for a couple of days over the donor site. You may be instructed to wear this support garment for 4-6 weeks post-operatively.

. Ice Packs should be applied as needed for the first 24 hours to the operation site.

PAIN

. For pain relief, take Vicodin 1-2 tablets every 4-6 hours as needed (not more than 8 per day. Do not make any legal decisions while under the influence of medications.

. Do not drink alcohol, drive or operate machinery while on medication or on the first day after surgery.

DIET

. Do not eat a heavy meal the first night after surgery. Commence with clear fluids followed by a light, soft diet.

WOUND CARE FOR DONOR SITE- FIRST WEEK

. Support garments or bandage may be removed and you may shower starting two days after surgery. Remove the dressing in the shower. You may leave the small incisions uncovered. If you prefer to keep them covered, apply fresh steri-strips after you shower and dab with Hydrogen Peroxide 3%.

. You may be required to wear the recommended stockings or support garment for 6 days and nights unless otherwise instructed.

. Stitches will dissolve spontaneously if stitches remain after a week, the nurse can remove them for you. You may tub bathe 24 after the procedure day.

WOUND CARE FOR OPERATION SITE

. Any bandages or dressings will be removed 48 hours following surgery in the shower.

. Clean the small incisions with Hydrogen Peroxide 3% and a Q-tip. Your stitches will dissolve or can be taken out 7 days post-operatively.

. Continue ice packs as needed.

. Swelling and bruising are a normal part of the recovery process and will begin to subside one or two weeks after surgery. It will take several weeks before the contour finalizes.

. If you experience sever pain, please call the office. Soreness is usual, severe pain is not.

ACTIVITY

. Return to sedentary type of work as desired. Driving and flying are permitted after 24-48 hours. Tennis, jogging and other vigorous sports may be resumed approximately two to three weeks after surgery.

PATIENT_____DATE_____

PHYSICIAN_____DATE_____

********For emergencies call our office at (949) 248-1900*******