



**Cedars
Minimally
Invasive
Surgical
Suite, PC**

CONSENT FOR LIPOLITE

PATIENT: _____

DATE: _____ **TIME:** _____

I hereby authorize _____, M.D., to perform LipoLite on the areas detailed below.

I fully understand that this procedure has limited application. No guarantee or assurance has been given to me by anyone as to the results that may be obtained. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that neither the anticipated nor the expected outcome may occur as a result of the operation or procedure.

The doctor has discussed in detail with me the information that is briefly summarized below:

LipoLite is a body contouring and sculpting technique. It is a means of reducing localized fat deposits that are difficult or impossible to remove with diet and exercise. LipoLite is not a technique for treating obesity. In the Tumescant technique of LipoLite a very dilute anesthetic solution is injected under the skin into the fatty tissue before it is removed. Afterward, compression garments are worn for drainage and support. Patients usually return to work after 1-2 days.

I clearly understand and accept the following:

1. The goal of LipoLite surgery, as in any cosmetic procedure, is improvement- not perfection.
2. The final result may not be apparent for 3-6 months post-operatively.
3. In order to achieve the best possible result, "a touch-up" procedure may be required.
4. Areas of "cottage cheese" texture (i.e. cellulite) will be changed little by the LipoLite procedure.
5. LipoLite surgery is a contouring-sculpting procedure and it is not performed for purposes of weight reduction, nor as a substitute for healthy diet and exercise.
6. Strict adherence to the post-operative regimen and instruction is necessary in order to achieve the best possible results.
7. **I have not taken any aspirin or aspirin-containing products for a minimum of Ten (10) days prior to my surgery.**
8. There is no guarantee, expressed or implied, that the expected or anticipated results will be achieved.
9. I understand that LipoLite surgery is contraindicated in certain patients (see below) and that I am not one of these patients:
 - a. Women who are pregnant or believe they might be pregnant.
 - b. Women who are nursing.
 - c. Patients with active thrombophlebitis or active infection.
 - d. Patients with poor circulation or confined to bed.
 - e. Patients with a history of pulmonary embolism or blood clots in the lungs.
 - f. Patients with a history of severe or multiple allergic reactions.
 - g. Patients with uncontrolled diabetes mellitus or uncontrolled collagen vascular disease (e.g. Lupus, etc)
 - h. Patients with a history of uncontrolled bleeding.
 - i. Patients with positive blood tests for Hepatitis.

- I authorize and consent to the usage of photographs or video taken before, during, or after surgery for teaching, marketing, scientific journals, and other viewing purposes.

Although complications following LipoLite are infrequent, I understand that the following may occur:

- Skin irregularities, lumpiness, hardness, and dimpling may appear post-operatively. Most of these irregularities disappear with time and/or massage, but localized irregularities may persist permanently. If loose skin is present in the treated area it may or may not shrink to conform to the new contour.
- Infection is rare, but should it occur, treatment with antibiotics and/or surgical drainage may be required.
- Numbness or increased sensitivity of the skin over treated areas may persist for months. Rarely, it is possible that localized areas of numbness or increased sensitivity could be permanent.
- Normal temporary side effects associated with LipoLite surgery include soreness, inflammation, bruising, swelling, numbness, and minor irregularity of the skin. Some of those effects can take several months to resolve.
- Objectionable scarring or pigment changes are unusual because of the small size of the incisions in LipoLite surgery, but scar formation or permanent pigment changes are possible.
- Surgical bleeding is very rare using the Tumescant technique of LipoLite surgery; however, it could theoretically require hospitalization.
- Temporary accumulation of fluid under the skin (seroma) may occur, requiring possible surgical drainage.
- In addition to these possible complications, I am aware of the general risks inherent in all surgical procedures and anesthetic administration. Although rare with Tumescant LipoLite surgery, unexpected severe complications can occur, including but not limited to: allergic reaction, paralysis, convulsions, blood clots, strokes, heart attack, brain damage, or even death.
- In the event of an emergency I hereby give my consent to my transfer to a nearby hospital. I understand that I am responsible for any transportation expenses incurred for my care during the time I am in transit between institutions, as well as any hospital, physician, laboratory, or radiological expenses.
- I confirm the surgeon and his/her staff have explained to me the nature, purpose, limitations, and possible consequences of LipoLite surgery, as well as risks involved. I have been advised that a more detailed and complete explanation of any foregoing matters will be given to me as I so desire, and I do not desire such further explanation. All questions have been answered to my satisfaction.
- The following is/are the areas of my body to be treated by LipoLite: (circle and initial)

<input type="checkbox"/> Abdomen, Lower	<input type="checkbox"/> Thighs, Outer	<input type="checkbox"/> Hips
<input type="checkbox"/> Abdomen, Upper	<input type="checkbox"/> Infero-Lateral Buttocks	<input type="checkbox"/> Waist
<input type="checkbox"/> Male Flanks	<input type="checkbox"/> Thighs, Inner	<input type="checkbox"/> Female Flanks
<input type="checkbox"/> Male Breasts	<input type="checkbox"/> Knees, Inner	<input type="checkbox"/> Posterior Axillary
<input type="checkbox"/> Chin, Jowls, Neck	<input type="checkbox"/> Thighs, Anterior	<input type="checkbox"/> Arms
<input type="checkbox"/> Platysmal Plication	<input type="checkbox"/> Knees, Anterior	<input type="checkbox"/> Buttocks

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date/Time

_____	_____	_____
Witness Name (Printed)	Witness Signature	Date/Time