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OPERATIVE CONSENT FOR FACIAL LASER RESURFACING SURGERY

Patient _____ Date _____

I am aware that laser surgery is a relatively new procedure. My doctor has explained to me that much of what has been written about this method in newspapers, magazines, television, etc. has been sensationalized. I understand the nature, goals, limitations, and possible complications of this procedure, and I have discussed alternative forms of treatment. I have had the opportunity to ask questions about the procedure, its limitations, and possible complications (see below).

I clearly understand and accept the following:

1. The goal of laser surgery, as in any cosmetic procedure, is improvement not perfection.
2. The final result may not be apparent for months postoperatively.
3. In order to achieve the best possible result, more than one procedure may be required. There will be a charge for any further operation performed.
4. Since adherence to the postoperative regimen (i.e. appropriate wound care and sun avoidance) is necessary in order to achieve the best possible result.
5. The surgical fee is paid for the operation itself and subsequent postoperative office visits. There is no guarantee that the expected or anticipated results will be achieved.

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

1. Bleeding which, in rare instances, could require hospitalization.
2. Infection is rare, but should it occur, treatment with antibiotics might be required.
3. Objectionable scarring is rare, but various kinds of scars are possible.
4. Alterations of skin pigmentation may occur in the areas of laser surgery. These are usually temporary, but rarely can be permanent.

In addition to these possible complications, I am aware of the general risk inherent in all surgical procedures and anesthetic administration outlined in the accompanying surgical consent form.

I agree that Dr. Gregory Stainer or designated associates may take photographs of my procedure and may use these photographs without compensations for me for teaching or medical publication providing my identity is concealed.

My signature certifies that I understand the goals, limitations, and possible complications of laser surgery, and that I wish to proceed with the operation.

Patient

Physician

Witness

Date