



Consent for Body Liposuction Surgery

I hereby authorize **Faisal A. Quereshy, M.D., D.D.S.**, as a qualified Maxillofacial Surgeon, and such assistants as he may designate, to perform upon:

BODY LIPOSUCTION AREAS AS LISTED: _____

I am aware that fat suction surgery has had many changes and improvements. Dr. Quereshy has explained to me that much that has been written about this method has been exaggerated and sensationalized. Dr. Quereshy has carefully explained the nature, goals, limitations and possible complications of the procedure to me and has discussed alternative forms of treatment including no-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 liposuction surgery, as in any cosmetic procedure, is improvement, not perfection.
- 2) The final result may not be apparent for 3 to 6 months following the procedure.
- 3) Areas of "cottage cheese" texture, i.e. "cellulite" may not be changed by the liposuction procedure.
- 4) Liposuction surgery is a contouring procedure and is not performed for the purposes of weight reduction.
- 5) Strict adherence to the post-operative regimen discussed by Dr. Quereshy (i.e. wearing an elastic support for several weeks or months, massage, exercise, diet) is necessary in order to achieve the best possible results.

COMPLICATIONS FOLLOWING LIPOSUCTION ARE INFREQUENT, I UNDERSTAND THAT THE FOLLWING MAY OCCUR:

- 1) Bleeding which in rare instances could require hospitalization and blood transfusion. It is possible that blood clots may form under the skin and require subsequent surgical drainage.
- 2) Skin irregularities, lumpiness, hardness, and dimpling may appear post-operatively. Most of these problems disappear with time and massage but localized skin firmness, lumpiness, and / or irregularities may persist permanently. If loose skin is present in treated areas it may not shrink to conform to the new contour. Excision or removal of this excess skin may be necessary and is a separate surgical procedure.
- 3) Infection is rare, but should it occur, treatment with antibiotics and / or surgical drainage may be required.
- 4) Numbness or increased sensitivity of the skin over treated areas may persist for several months. It is possible that localized areas of numbness or increased sensitivity could be permanent.
- 5) Objectionable scarring is rare because of the small size of the incisions used in liposuction surgery, but scar formation is possible.
- 6) Dizziness may occur during the first week following liposuction surgery particularly upon rising from a laying or sitting position. If this occurs, extreme caution must be exercised while walking. Do not attempt to drive a car is dizziness is present.
- 7) I understand and give my consent to the use of an additional unit or units of banked blood should more blood be required than what I was asked to donate, and if the doctor determines that it is medically necessary during the surgery.

I furthermore know and understand that the practice of Medicine and Surgery is not an exact science, and that, reputable physicians cannot guarantee any specific results. No guarantee(s) or assurance has been given to me by **Faisal A. Quereshy, M.D., D.D.S.**, or his staff, as to the expectations or results that may be achieved. I have been completely honest with my surgeon regarding my motivation for undergoing cosmetic surgery realizing that a new appearance does not guarantee an improved life. THERE IS NO GUARANTEE THAT THE EXPECTED OR ANTICIPATED RESULTS WILL BE ACHIEVED.

I have discussed my past medical, health and social history, including drug and alcohol use, recognizing that withholding information may affect the planned goals of surgery. I agree to cooperate fully while under treatment, realizing that lack thereof can lead to an undesirable result, or may be life-threatening. If I use tobacco, I understand that I must cease the use of all tobacco products at least two weeks prior to surgery. Failure to do so may have serious negative effects on the success of my surgery.

I certify that I have had the opportunity to fully read this consent. I am likewise satisfied that any and all possible alternative methods of treatment have been thoroughly explained. My signature below indicates my agreement and understanding of my proposed treatment and I hereby give my willing consent to the surgery.

 Patient's (or Legal Guardian's) Signature

 Date

 Doctor's Signature

 Date

 Witness' Signature

 Date

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*Fellow American College of Surgeons • Diplomate American Board of Oral and Maxillofacial Surgery
 Board Certified American Board of Cosmetic Surgery • Fellow American Academy of Cosmetic Surgery*