Acceptance Of Risk And Surgery Consent

Surgeon and patient initial each

	Surgeon	Patient
If signs of rupture are seen on an MRI, then you should have your implant removed.	_____	_____
Additional surgery to your breast and/or implant will be likely over the course of your life.	_____	_____
Your implants are not considered lifetime devices and you will likely undergo implant removal, with or without replacement, during your life.	_____	_____
You should inform your mammography technologist about the presence of your implants.	_____	_____
Your breast implants may interfere with your ability to successfully breastfeed.	_____	_____
You should perform breast self-examinations monthly and should make sure you know how to distinguish the implant from your breast tissue.	_____	_____
To monitor your breast implants for silent rupture, an MRI is recommended three (3) years following surgery and then every two (2) years after that.	_____	_____
The scar tissue or capsule that normally forms around the implant may tighten (contracture) and squeeze the implant making your breast feel firmer and sometimes painful.	_____	_____
Allergan maintains a breast implant Device Tracking database and your participation in this database is strongly recommended.	_____	_____

Consent To Surgery

My surgeon has provided me with the AUGMENTATION SURGERY WITH SILICONE GEL-FILLED BREAST IMPLANTS PATIENT PLANNER to inform me prior to my surgery.

I have had adequate time to review and understand the information presented in the AUGMENTATION SURGERY WITH SILICONE GEL-FILLED BREAST IMPLANTS PATIENT PLANNER. My concerns and questions have been addressed by my doctor. I have considered alternatives to augmentation surgery including use of external prostheses or surgery with saline-filled breast implants.

I am choosing to proceed with silicone gel-filled breast implant surgery.

Patient Name (Printed):_____

Patient Signature:_____ Date:_____

Surgeon Name (Printed):_____

Surgeon Signature:_____ Date:_____

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