BREAST AUGMENTATION INFORMATION AND CONSENT

ABSOLUTE
COSMETIC MEDICINE

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

1. I (please print and initial beside your name) _____
have read and understood the F.D.A and T.G.A breast information and viewed the complications slides.

2. Before my consultation with Dr Murray, I will express preliminary preferences and choices. I understand that if Dr Murray feels that my choices might have negative short-term or long-term effects on my tissues or my chances for the best result with the least risk of complications, he will discuss these issues with me during our consultation.

3. I understand that Dr Murray can enlarge my breasts as much as possible but he is limited by the characteristics of my tissues. I also understand that the choices I make, particularly concerning implant size, can affect the appearance of my breasts as I get older and can affect my risks of having complications or needing additional operations in the future.

4. Medical history information: Please complete the Medical History Information Document that is included on page 8 of this document.

5. Please tick **one** of the following concerning the BREAST SIZE YOU DESIRE:

☐ **5a.** I want a MINIMAL amount of enlargement.

☐ **5b.** I want to be AS FULL AS I CAN BE AND ACHIEVE A NATURAL APPEARING BREAST THAT IS SAFEST FOR MY TISSUES LONG TERM. I leave the choice of implant size under these circumstances entirely to Dr Murray and will accept the size of breast that he feels is safest for my tissues long term.

☐ **5c.** **(Please fill in ALL blanks)** I want a SPECIFIC SIZE BREAST - at least a _____ cup size AND at least a _____ cc implant. *(This option is chosen if you have chosen an implant size)*

6. Please tick **one** of the following with respect to CHOICE OF BREAST SIZE AND RISK OF FUTURE PROBLEMS:

☐ **6a.** I WANT A BREAST SIZE THAT WILL HAVE THE LEAST CHANCE OF CAUSING FUTURE SAGGING, COMPLICATIONS, OR NEED FOR ADDITIONAL PROCEDURES SUCH AS A BREAST LIFT. I understand that Dr Murray will choose an implant that will produce the fullest breast possible that is safest long-term unless I specify a smaller or larger breast. I leave the choice of implant size entirely to Dr Murray based on his evaluation of my tissues and body proportions. I understand and accept that Dr Murray cannot guarantee a cup size of my result, and I will not request a larger implant following my augmentation.

☐ **6b.** I WANT A SPECIFIC BREAST SIZE, THIS MAY BE LARGER THAN IDEAL FOR MY TISSUES. If I want a larger implant than Dr Murray feels is optimal for my tissues, I understand that I may not have a natural-appearing breast. I am willing to accept all responsibility for appearance and risks of re-operation, complications, deformities, additional costs, time off work and normal activities that may result from my selecting an implant that is larger than ideal for my tissues.
(This option is chosen if you have chosen an implant size)

Patient Initial: _____ I have read, understood and agree to all information provided on this page.

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7. Please tick one of the following concerning HOW YOU WOULD LIKE YOUR BREASTS TO LOOK.
Three to six months after my augmentation (after my tissues relax) I want the upper portion of my breast to appear:

☐ **7a.** Inwardly curved, NOT FILLED IN THE UPPER PORTION OF THE BREAST.

☐ **7b.** FULL IN THE UPPER BREAST, with a straight or slightly outwardly curved profile in the side view.

☐ **7c.** EXTREMELY FULL, WITH A VERY BULGING UPPER BREAST. I understand and accept that this choice produces a breast that does not appear natural and may have excessive bulging with an unnatural appearing transition from the upper chest to the breast. I also understand that an excessively large implant can cause damage to my tissues long-term that could cause me to need additional operations or have permanent deformities, but I want the large implants regardless of those possible consequences.

8. IMPLANT SHAPE FOR MY PROCEDURE:
We do not use anatomical implants as they have more risks and fewer benefits.

☐ **8a.** Round

9. IMPLANT SHELL TYPE that I prefer
Please choose and tick only one of the following two options:

☐ **9a.** Textured (may take 5-18 months to settle for the final result)

☐ **9b.** Smooth (may take 6-12 months to settle for the final result)

10. IMPLANT MANUFACTURER: I want Dr Murray to choose the implant manufacturer.

11. IMPLANT SIZE that I prefer
Please choose and tick only one of the following two options:

☐ **11a.** I want an implant that contains at least _____ cc of filler *(refer to section 5C if you have chosen a specific size.)*

☐ **11b.** I have no specific preference for the number of cc's in my breast implant, and I want Dr Murray to choose based on his evaluation of my tissues and proportions. If I ask Dr Murray to choose the appropriate size implant that is best for me, I will abide by his choice, understanding that he will fill my breast as much as he feels it can be filled safely, without producing additional risks or trade-offs.

12. If, after surgery, for any reason, I desire a different size implant, I understand and accept that I must specify the exact type and size of the implant in cc's and that I am completely responsible for all costs associated with changing my implants, including surgeon fees, anaesthesia fees, laboratory costs, and surgery facility fees. Further, I will not expect Dr Murray to co-operate to correct any problems that may occur as a result of my requests for a larger or different implant.

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13. Implant pocket location that I prefer
Please choose and tick only one of the following three options:

☐ **13a.** I prefer my implant to be placed partially UNDER muscle. I have read and fully understand and accept the trade-offs of placing an implant partially under the muscle (dual plane).

☐ **13b.** I prefer my implant be placed ABOVE muscle. I have read and fully understand and accept the trade-offs of placing an implant above muscle, and I understand and accept that I may see visible implant edges or other irregularities if the implant is placed subfascial or subglandular above the muscle.

☐ **13c.** I do not have a preference for over or under the muscle, and I want Dr Murray to choose according to my tissue requirements. I have read and fully understand the trade-offs of placing an implant either over or under the muscle.

14. I would like Dr Murray to choose my incision location based on his assessments of my needs and optimal control during the operation and I will abide by his decision.

15. From my reading and information provided to me, I understand and accept that there are several factors related to my individual tissue characteristics, how I heal, and how my tissues respond to my breast implants that Dr Murray cannot predict by tests before surgery and cannot control after surgery.

16. I understand and accept that Dr Murray must work with what I bring him to work with and that he cannot change the qualities of the tissues of my breasts that can stretch following surgery or affect how I will heal. I also understand and accept that Dr Murray cannot perform tests before surgery, or in any other way predict;

16a. how my skin will stretch following my augmentation.

16b. how my body will heal or not heal following my augmentation.

17. I fully understand and accept that if I develop an infection following my augmentation, Dr Murray may remove both of my breast implants, and may never replace either implant to minimise further re-operations, risks and costs to me. I further understand and accept that, if the implant removal is ever required for any reason, any resulting deformities may not be completely correctable.

18. I understand and accept that Dr Murray has absolutely no control over how my body heals following my breast augmentation and that he cannot predict (by tests before surgery) or control my individual healing characteristics.

19. I understand and accept that my body will form a lining (capsule) around my breast implant following my augmentation and that the capsule around the implant may contract (tighten) excessively, causing a variety of deformities that may require additional surgery. Despite additional surgery, these deformities may be uncorrectable and require implant removal. The capsules that form and the amount that they tighten are never equal on both sides, so the effects of the capsule on each breast are usually different.

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20. I understand and accept that there are no tests or medical information that can accurately predict whether my capsules will tighten excessively and that following my augmentation, Dr Murray has no control over how my body forms the capsule or how much the capsule will tighten or cause deformity.

21. I understand and accept that any of the following deformities can result from how the capsule forms and tightens and that Dr Murray cannot predict, prevent or control the occurrence of any of these deformities:

21a. Closing of a portion of the lower implant pocket (can be mild or severe), causing slight or significant upward displacement of the implant and raising the fold under the breast leaving the incision scar below the fold (if the incision was made under the breast).

21b. Closing of a portion of the outside of the implant pocket, causing flattening of areas of the outside contour of the breast and inward displacement of the implant.

21c. Excessive firmness of the implant or breast.

21d. Visible edges or bulging deformities in any area of the breast.

21e. The quality of the scar that will form wherever my incision is located.

21f. The effects of my body healing and scarring in the area of the incision, adjacent areas to the incision or breast, or any area of the breast.

21g. Discomfort or pain in areas of the breast.

21h. Change in sensation or loss of sensation in any area of the breast or adjacent areas.

21i. Occurrence of lymph node enlargement or small bands near the incision caused by incision or obstruction of small lymph vessels (both of which usually subside without treatment in 3-6 weeks).

22. I understand and accept that any or all of these deformities can occur in one or both breasts, and do not occur equally on the two sides. Although breasts never match exactly on the two sides, if any of these deformities occur, differences in the two breasts may be more noticeable and may not be correctable.

23. I understand and accept that if any or all of the deformities caused by my healing characteristics or the characteristics of the capsule (lining) around my implants occur, even though the deformity may be visible, that Dr Murray alone will determine whether additional surgery is needed. Dr Murray will base this decision on whether he feels the potential benefits outweigh the potential risks of additional surgery and whether he feels I will get predictable improvement from additional surgery. I agree to abide by Dr Murray's decisions in all matters concerning whether or not additional surgery is performed.

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24. I understand and accept that if any of the deformities listed above occur following my augmentation, that additional surgery will not change the qualities of my tissues and the healing characteristics that caused the deformity in the first place. As a result, additional surgery to correct these deformities:

24a. is unpredictable at best due to the limitations of my tissues and healing characteristics.

24b. that surgery for any of these deformities listed above may not successfully correct the deformity.

24c. that any or all of these deformities can occur again after additional surgery because of my healing characteristics.

25. If my tissues stretch excessively in any area following my augmentation, deformities can result over which Dr Murray has no control. These deformities include the following:

25a. excessive sagging or "bottoming out" of the breast with the implant too low and the nipple pointing excessively upwards.

25b. a shift of the implants to the sides with a widening of the gap between the breasts.

25c. thinning of tissues over the implant allowing the implant to become visible or palpable (able to be felt) in any area.

25d. visible rippling in any area that can result when the implant pulls on the overlying tissue.

26. I understand and accept that any or all of these deformities can occur in one or both breasts and do not occur equally on the two sides. I also understand and accept that the larger the breast implant I choose or that my breasts require for optimal aesthetic results, the greater the risk of these deformities occurring. Although breasts never match exactly on both sides, if any of these deformities occur, differences in the two breasts may be more noticeable and may not be correctable.

27. I understand and accept that if any or all of the deformities caused by tissue stretch listed above should occur, even though the deformity may be visible, Dr Murray alone will determine whether additional surgery is needed. Dr Murray will base this decision on whether he feels the potential benefits outweigh the potential risks of additional surgery and whether he feels that I will get predictable improvement from additional surgery. I agree to abide by Dr Murray's decision in all matters concerning whether or not additional surgery is performed.

28. I understand and accept that if my tissues stretch excessively for any reason following my augmentation, that additional surgery will not change the quality of my tissues that allowed them to stretch in the first place. As a result, additional surgery to correct stretch deformities is unpredictable. At best, due to the limitations posed by my tissues, surgery for any stretch deformities may not be successful. Any or all of these deformities can occur again if my tissues stretch. I understand and accept that if my tissues stretch excessively after surgery to correct a stretch deformity, Dr Murray may recommend that I remove and not replace my implants to avoid possible permanent uncorrectable deformities.

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29. Since Dr Murray cannot predict or control my tissue characteristics or healing characteristics and how they will affect my chances of developing any of the deformities listed above related to tissue stretch and thinning or capsule or scar tissue formation following my augmentation, I understand and accept that should any of the deformities listed below (29 a - l) occur, if surgery is necessary to try to improve any of the following conditions, I will be personally responsible for all costs associated with surgery that is performed.

Please tick beside each number indicating your complete understanding and acceptance of all costs associated with surgery for each deformity.

☐ **29a.** Excessive sagging or "bottoming out" of the breast with the implant too low and the nipple pointing excessively upwards.

☐ **29b.** Shift of the implants to the sides with a widening of the gap between the breasts.

☐ **29c**. Thinning of tissues over the implant, allowing the implant to become visible or palpable (able to be felt) in any area.

☐ **29d.** Visible rippling in any area can result when the implant pulls on the overlying tissues. Plus deformities such as, but not limited to, double bubble and snoopy deformity.

☐ **29e.** Closing of a portion of the lower implant pocket (can be mild or severe), causing slight or significant upward displacement of the implant and raising the fold under the breast leaving the incision scar below the fold (if the incision was made under the breast).

☐ **29f.** Closing of a portion of the outside of the implant pocket, causing flattening of areas of the outside contour of the breast and inward displacement of the implant.

☐ **29g.** Excessive firmness of the implant or breast.

☐ **29h.** Visible edges or bulging deformities in any area of the breast.

☐ **29i.** Discomfort or pain in the areas of the breast.

☐ **29j.** The effect of my body healing and scarring in the area of the incision, adjacent areas to the incision or breast, or any area of the breast.

☐ **29k.** Change in sensation or loss of sensation in any area of the breast or adjacent areas.

☐ **29l.** Occurrence of lymph node enlargement or small bands near the incision caused by incision or obstruction of small lymph vessels (both of which usually subside without treatment in 3-6 weeks).

30. I understand and accept I will be personally responsible for prepaying all costs of any additional surgery at least two weeks before the scheduled surgery.

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31. I understand and accept that costs for any additional surgery following my augmentation will likely exceed the costs of my original augmentation surgery and that the costs are determined by the complexity and length (time) of the surgery required. Fees for additional surgery will include laboratory fees, electrocardiogram fees if I am over 40 or have a heart condition, possible mammogram or MRI imaging fees, Dr Murray's surgeon fees, anaesthesia fees, surgical facility fees, and costs of take-home medications. I accept personal responsibility for all these fees and in addition, I understand and accept that I may have additional costs associated with time off work or normal activities.

32. If following my breast augmentation, any additional surgery for the reasons listed above becomes necessary and I later choose to dispute any of the items above for which I have indicated my full understanding and acceptance, I agree to pay all of Dr Murray's costs, including any legal fees, court costs or any other costs associated with resolving the dispute.

33. I understand and accept that my breast implants may experience deflation (if I have inflatable implants) or shell disruption or rupture (if I have silicone gel-filled implants) and that it is impossible for my surgeon to predict the life span of my implants. If deflation or shell disruption occurs, I understand and accept that I am responsible for all costs associated with surgery and time-off normal activities to replace my implants and that any/all warranties for my implants are with the manufacturer of my implants, not with my surgeon. I accept that whether or not I choose to participate in any warranty program with the manufacturer of my breast implants, I am personally responsible for all costs associated with replacing my implants.

34. I understand there is a risk of lymphoma, breast implant illness, death and possible diagnostic difficulties with breast implants.

35. I understand I must be compliant with all aftercare and cease smoking at least 2 weeks before my procedure and for 6 weeks post-operation.

36. I cannot dispute what I have read, agreed to and signed above. If I do then I agree to pay all costs incurred by ACM if I breach this agreement. I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy. I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records.

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I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that I have been given the opportunity to have all my questions answered, and that I (we) understand its contents.

Signed this _____ day of the month of _____, 20_____ .

Patient Name *(please print):* _____

Patient Signature:_____

Witness name *(please print):*_____

Witness Signature:_____ Date:_____

Please select one of the choices below:

☐ I have made a copy of this document for my personal records.
☐ I do not desire a copy of this document for my personal records.

MEDICAL HISTORY INFORMATION FOR:

Patient Name *(please print):* _____

Patient Signature: _____ Date:_____

1. Do you or have you had:

	YES	NO
1a. Any family history of blood clotting or clots to the lungs?	☐	☐
1b. Any known genetic predisposition to blood clotting disorders?	☐	☐
1c. Swelling in your legs?	☐	☐
1d. Blood clots in your legs or elsewhere?	☐	☐

If yes to any of the above, please describe: _____
_____
_____

2. List all medications you take including aspirin, hormones, birth control, and natural or homeopathic medications:

MEDICATION:_____

DOSE: _____

FREQUENCY TAKEN: _____

3. Are you allergic or do you have reactions to medications, drugs, or local anaesthetic medications?

MEDICATION:_____

REACTION WHEN LAST TAKEN:_____

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4. Do you or have you had:

	YES	NO
a. Aspirin intake in the past two weeks (avoid asprin for two weeks prior to surgery)	☐	☐
b. Family history of prolonged bleeding	☐	☐
c. Have you had blood transfusions	☐	☐
d. Prolonged bleeding when cut	☐	☐
e. Reactions to blood transfusions	☐	☐
f. Fainting or blackout episodes	☐	☐
g. Blood pressure problems - *date last taken:* _____	☐	☐
h. Hepatitis	☐	☐
i. Heart problems	☐	☐
j. Hearing problems	☐	☐
k. Pacemaker	☐	☐
l. Vision problems	☐	☐
m. Ulcer disease	☐	☐
n. Removable dental work	☐	☐
o. Mobility problems	☐	☐
p. Permanent dental caps, fillings etc	☐	☐
q. Arthritis	☐	☐
r. Diabetes	☐	☐
s. Chest pain or shortness of breath	☐	☐
t. Urinary problems	☐	☐
u. Bowel problems	☐	☐

v. Date of last menstrual cycle:_____

w. Other significant illness? If so, describe _____

_____

5. Previous operations date: _____

6. Have you formed excessive or unsatisfactory scars in the past?

7. Is there a history of the following in your immediate family? *If so please list the family member beside the disease*

	FAMILY MEMBER	YES	NO
a. High blood pressure	_____	☐	☐
b. Heart attack	_____	☐	☐
c. Diabetes	_____	☐	☐
d. Cancer (type)	_____	☐	☐
e. Hepatitis	_____	☐	☐
f. Stroke	_____	☐	☐

8. Your Occupation: _____

9. Do you smoke? No. of cigarettes per day _____	☐	☐
10. Do you drink alcohol? No. of drinks per day _____	☐	☐
11. Do you use ANY other drugs or medications?	☐	☐

*If yes, please list:*_____

Patient Name *(please print):* _____

Patient Signature: _____ Date:_____

Witness name *(please print):*_____

Witness Signature:_____ Date:_____

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