CONSENT FOR PDO THREAD LIFT PROCEDURE OR TREATMENT

I, _____ hereby authorise [Physician Name or Practice Name] to perform the PDO thread lift procedure.

- [Physician Name or Practice Name] has explained to me the potential benefits and risks of this surgery, the details of the technique, and the materials used. [Physician Name or Practice Name] has also explained the possible temporary complications as well as the recovery period. I have received information on the physical and mental consequences of having a thread lift procedure.
- I understand that the final results of the procedure will not be seen for a period of 4- 8 weeks. I understand that there may be possible adjustments required after the procedure as a result of individual responses depending on tissue settlement.
- I recognise that during the course of the operation and medical treatment or anaesthesia, unforeseen circumstances may necessitate modifying the procedure, resulting in different procedures(s). I therefore authorise [Physician Name or Practice Name] and his staff to perform such other procedures that are in his or her professional judgement necessary or desirable.
- I have advised my [Physician] of my medical history including all previous illnesses and medications currently being taken.
- I consent to the administration of such anaesthetics considered necessary or advisable. I understand that all forms of anaesthesia involve risk and the possibility of complications and injury.
- I acknowledge that no guarantee has been given regarding the results that may be obtained.
- I understand that antibiotics are required after the procedure if prescribed by the [Physician Name or Practice Name]. I understand that there is a minimal risk of infection and if I am unable to take the antibiotics prescribed, this increases the risk of contracting an infection. In the event that an infection occurs I understand that I must contact [Physician Name or Practice Name] immediately and follow the necessary treatment.
- I understand that I am required to attend post-operative check-ups as advised by [Physician Name or Practice Name] for the best outcome for the procedure.
- In the event of the necessary removal of one or more of the threads I accept that such procedure be carried out by [Physician Name or Practice Name].

Patient Name: _____

- For the purposes of advancing medical education, I consent to the admittance of observers to the procedure room.

- I consent to the disposal of any tissue and/or medical devices that may be removed.

- I consent to photographs being taken as a record of treatment: such photographs will not be used for any other purpose without my express permissions.

I hereby consent to the thread lift procedure. I have read the material given to me and I am satisfied that all of my questions and concerns have been addressed.

Patient Name:
_____

Signature: _____ Date:
_____

[Physician Name or Practice Name]

Authorized Signature: _____ Date: _____

Patient Name: ____