INFORMED CONSENT FOR SUBCUTANEOUS MASTECTOMY

1. No implied guarantee of cure of protection against malignant disease of tumors in opposite breast or remaining tissue in area of previous surgery
2. Bleeding with need of surgical evacuation
3. Infection
4. Asymmetry in size, shape, position and contour of breast and or nipple areolar complex
5. Possible partial or total loss of nipple areolar complex of breast gland
6. Permanent, noticeable and non-cosmetic scars
7. Need for revisional or further staged surgical procedure, including surgery on the opposite breast
8. Subcutaneous mastectomy is an elective procedure
9. Smoking and use of nicotine in any form is detrimental and can lead to poor healing with skin necrosis and loss

The complications and limitations of the above-mentioned procedure have been explained to me in detail and in terms I can understand. I am aware that the possibility of unforeseen complications also exists. I have been given the opportunity to question each point listed and have been informed of alternative treatment options, including the option of no treatment.

I understand that any clinical photographs or X-rays taken of me are the property of the physician and may be used for medical education.

In the event that revisional or secondary procedures are required, I understand that I will be responsible for both facility and anesthesia fees.

I hereby request, authorize, and give my consent to Christopher J. Kovanda, M.D. to perform the above named procedure and or whatever other treatment he may deem advisable in the diagnosis and treatment of my case.

____________________________________  _________________________
Patient Signature                        Witness