

**Consent Form Orbital and Facial Plastic Surgery**  
**John R. Burroughs, M.D., P.C.**

You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. **Condition(s):** Dr. Burroughs has explained to me that the following condition(s) exist in my case: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. **Proposed Procedure(s):** I understand that the procedure(s) proposed for evaluating/treating my condition is/are:  
Right Blepharoplasty Ptosis (Brow/Lid) repair Canthopexy Canthoplasty Conjunctivoplasty Tarsal strip Retraction repair  
Entropion repair Myocutaneous advancement flap Orbicularis Flap Punctal occlusion Punctoplasty  
Dacryocystorhinostomy Ethmoidectomy Stent placement Temporary tarsorrhaphy Wedge Correct Retraction  
Left Blepharoplasty Ptosis (Brow/Lid) repair Canthopexy Canthoplasty Conjunctivoplasty Tarsal strip Retraction repair  
Entropion repair Myocutaneous advancement flap Orbicularis Flap Punctal occlusion Punctoplasty  
Dacryocystorhinostomy Ethmoidectomy Stent Placement Temporary tarsorrhaphy Wedge Correct Retraction

Bilateral

Others

3. **Risks/Benefits of Proposed Procedure(s):**

- A. Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.
- B. I also realize that there are particular risks associated with the procedure(s) proposed for me and that these risks include, but are not limited to, those enumerated in the addendum.

4. **Complications; Unforeseen Conditions; Results:** I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur, and it is impossible for the physician to inform me of every possible complication that may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. Due to individual differences in anatomy, response to surgery, and wound healing, I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment. Further medical or surgical treatment may be needed, and this can incur additional costs NOT included in the original surgical fees.

5. **Acknowledgments:** The available alternatives, some of which include (e.g., no surgery) \_\_\_\_\_, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment, (e.g. worsening or no improvement) \_\_\_\_\_ have been explained to me. I understand what has been discussed as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

6. **Consent to Procedure(s) and Treatment:** Having read this form and talked with the physician, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted by hospital, other surgical personnel, or other trained persons as well as the presence of observers.

X \_\_\_\_\_  
Patient (or person authorized to sign for patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

[SEE ADDENDUM]

**Consent Form Orbital and Facial Plastic Surgery**  
**John R. Burroughs, M.D., P.C.**

**ADDENDUM to General Consent Form:**

Complications which could last or occur weeks, months, or even years later:

1. Loss of vision or blindness, new eyeglasses prescription change is rarely needed
2. Injury or Loss of eye
3. Changed vision or Double vision
4. Disfigurement/Scarring/Asymmetry
5. Hemorrhage, infection, poor wound healing
6. Failure to solve problem or possible aggravation of problem
7. Possible necessity for multiple additional procedures, including surgery, chemotherapy and radiation
8. Eyelid malposition, possibly requiring additional treatment/surgery; tightness
9. Tearing or eye irritation, pain, dryness
10. Possible penetration of sinuses/ intracranial space with attendant complications such as meningitis or spinal fluid leak
11. Sensory (numbness) or motor loss on face
12. Prolonged and very rarely permanent swelling and/or skin coloration changes

Local complications of anesthesia injections around the eye:

- |                                |  |
|--------------------------------|--|
| 1. Perforation of eyeball      | 2. Destruction of optic nerve              |
| 3. Possible drooping of eyelid | 4. Interference with circulation of retina |
| 5. Respiratory depression      | 6. Hypotension (Low Blood Pressure)        |

Additional comments: No guarantee of surgical success has been made and complications, though not anticipated, have been known to occur with operations even though every precaution for a safe surgery was undertaken. I realize there will be a scar or scars after the surgery, but I realize every effort will be made to minimize these. Additional treatments or surgery may be required that incur additional cost.

Blood Thinners Comments: Many agents thin blood and make surgery riskier (e.g., potentially permanent vision loss, prolonged/poor healing): prescribed aspirin, plavix, coumadin, lovenox, pradaxa, xarelto, eliquis, others; over-the-counter supplements/herbals, e.g., fish oils, ginkgo, Limu etc.; and over-the-counter Non-acetaminophen (Tylenol) pain relievers e.g., NSAIDS-motrin, alleve, advil etc.. On the other hand, stopping physician prescribed blood thinners (aspirin, plavix, coumadin, pradaxa, xarelto, eliquis, lovenox, heparin or others) before surgery may increase risks for heart attack, stroke, or life-threatening blood clots.

X  
\_\_\_\_\_  
Patient (or person authorized to sign for patient)

\_\_\_\_\_  
Date