



Left Right Bilateral Modified Radical Mastectomy

### Consent Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Guardian Name: (if applicable): \_\_\_\_\_

Patient ID: \_\_\_\_\_

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

#### 1 MY PROCEDURE

I hereby give consent for Dr. \_\_\_\_\_ to perform a Left Right Bilateral Modified Radical Mastectomy (and possible removal of additional lymph nodes) upon me. I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to treat and further evaluate breast cancer.

**I understand that the procedure or treatment can be described as follows:**

Removal of the breast with possible removal of lymph nodes.

This procedure will require anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

#### 2 MY BENEFITS

**Some potential benefits of this procedure include:**

- Removal of breast cancer for cure and staging

#### 3 MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.

**These could include but may not be limited to the following**

- Infection
- Bleeding
- Cosmetic changes/issues (including flap necrosis, axillary “web”, redundant tissue)
- Seroma (fluid accumulation in the operative site which may require aspirations(s))
- Lymphedema (up to 27% after node dissection)
- Possible numbness near the incisions or behind the arm, nerve damage producing “winged scapula” or weak muscles (numbness of the chest wall area is expected)
- Chronic pain (up to 20-30%)
- Other rare complications are also possible

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

**I understand these special risks of this procedure and that these can be affected by obesity, diabetes, smoking, other factors.**

**4 MY CONSENT**

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures.**

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required.**

I understand that frequently a permanent marker clip is placed for future reference on my mammograms.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to observation only. These alternative forms of treatment have their own potential risks, benefits and possible complications.

**I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.**

I understand the potential risks, complications and side effects involved with the proposed Left Right Bilateral Modified Radical Mastectomy and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

<p><b>Patient Signature:</b> _____ <b>Date:</b> _____ <b>Time:</b> _____</p> <p>Patient is unable to consent because _____. I Therefore consent for the patient.</p> <p>Authorized Consenter's Signature: _____ Date: _____ Time: _____</p> <p>Printed Name: _____ Relationship to Patient: _____</p> <p><input type="checkbox"/> Mark this box if telephone consent</p> <p>Witness Name (Print Name): _____</p> <p><b>Witness Signature:</b> _____ <b>Date:</b> _____ <b>Time:</b> _____</p>
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<p>By my signature below I attest to the fact that I explained the procedure to the patient</p> <p>Physician Name (Print Name): _____</p> <p><b>Physician Signature:</b> _____ <b>Date:</b> _____ <b>Time:</b> _____</p>
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