

# BERNSTEIN MEDICAL, P.C.

## Consent for Scar Revision

I, \_\_\_\_\_, hereby grant permission for

Robert M. Bernstein, M.D., a physician of the Bernstein Medical, P.C. (BMPC), and his assistants, to perform a surgical scar revision with or without the transplantation of the associated hair, including the administration of anesthetics and sedatives, by oral, intramuscular, or inhalation as may be necessary or desirable to do this procedure for the treatment of hair loss. The procedure has been thoroughly explained to me by the physician, and I fully understand the nature and consequences of the procedure.

I understand that the procedure is cosmetic in nature and that I have the option of doing nothing at all or having it surgically excised. I further understand that the procedure may not improve my condition; the procedure may worsen my condition; or the procedure may need to be re-done. These options have been discussed with me and have been fully explained by the physician.

I understand that there are risks involved in any surgical procedure or treatment and that it is not possible to guarantee or to give assurance of a successful result or to assure an outcome which will meet my goals or guarantee my happiness. I recognize that I have been given every opportunity to ask questions upon which I have made the decision to go forward with the surgery. I clearly understand and agree to the planned surgical procedure. I have been told that hair transplantation is a generally safe procedure; however, I realize that the following are possible events or complications that may occur.

- **SCARRING:** Every time an incision is made in the human body, a scar will occur, although every effort will be made to make the scar as inconspicuous as possible. Superficial crusting, pinkness, or redness of the incision area may occur, but these effects are usually temporary. Rarely, some area of skin around the suture edges may be lost and this will cause deep crusting which will take longer to heal. A stretched, widened scar is possible as is a thickened or raised scar (hypertrophic scar/keloid). Significant scarring is more likely to occur in people who have had a history of the above types of scarring or who have had previous transplants taken from the donor area.
- **ANESTHESIA REACTIONS:** Local anesthetics (lidocaine, bupivacaine) with Adrenaline (epinephrine) may have effects on many of the body's organ systems, including the heart. Such effects may include allergic reactions, irregular heartbeats, or even, in under unusual circumstances, a heart attack. Such risks are uncommon with surgical procedures performed under local anesthesia. Patients on the type of heart or blood pressure medication called "beta-blocker" may be particularly sensitive to epinephrine. Some patients may experience a temporary light-headed episode as a nervous reaction to injections. This reaction may cause a drop in blood pressure and lead to fainting. This condition is easily and relatively rapidly treated. If you are on any heart or blood pressure medication please list below. I am currently taking \_\_\_\_\_.  
I am not on any heart or blood pressure medication \_\_\_\_\_ (Please initial)
- **ALLERGIC REACTIONS:** I understand that there may be unusual, unexpected or allergic responses to drugs, medications, suture materials, or foods, prescribed or used during the surgical procedure. I recognize that it is important for the physician to be informed of any problem I, or any member of my family, have had with reactions to drugs and also the medications I have taken in the past six months, including over-the-counter drugs, especially aspirin and any street drugs.  
I am allergic to \_\_\_\_\_.  
I am not allergic to any drugs, medications, suture materials, or foods. \_\_\_\_\_.  
(Please initial)

- **STEROIDS:** Cortisone injections are used routinely to minimize swelling after the hair transplant. I understand the slightly increased risk of this treatment, including the rare complication of degeneration (aseptic necrosis) of the hip joint. I understand the nature of this cortisone treatment and agree to this preventative treatment. \_\_\_\_\_. (Please initial)
- **FOLLICULITIS:** Folliculitis is an uncommon problem in which hair follicles become infected with bacteria, that usually appears in the post operative period. The associated symptoms include redness around the grafts, pustules where the hairs come out, and itching. There may be some associated loss of hair in the involved follicles, but since the problem is localized to individual hair follicles, the loss is rarely significant from a cosmetic standpoint. The treatment consists of oral antibiotics that may be given for an extended period of time.
- **HAIR LOSS:** There may be temporary hair loss in the back of the scalp in the area surrounding the removed strip of hair which will generally grow back. Less commonly, there may be permanent loss of hair in the skin adjacent to the surgical incision. In the transplanted area, you may experience shedding of your existing hair following the surgery (a process called telogen effluvium). If this hair is at or near the end of its normal life span (miniaturized hair), it may not return. Because genetic balding is a continuous process, you may continue to lose more hair over time. If this were to occur, a subsequent hair transplant procedure may be desired.
- **HAIR TEXTURE CHANGES:** When your new hair begins to grow it may be more kinked or wavy than your original hair. Over time the hair generally resumes its normal character. It is possible that these hair texture changes may persist.
- **FAILURE OF TRANSPLANTED HAIR TO GROW:** As in all surgical procedures results cannot be guaranteed. It is possible that some or all of the transplanted hair may fail to grow. Every effort will be made to give you the maximum yield from your transplanted hair.
- **NUMBNESS AND PAIN:** Numbness of the scalp may occur due to necessary cutting of fine nerve fibers in the skin. This is expected to gradually disappear over several months, but it is possible that all of the sensations may not return. Rarely, sensory nerve injury may occur, resulting in long term or possibly permanent numbness and/or pain in the scalp.
- **SMOKING:** Smoking causes constriction of blood vessels and decreased blood flow to the scalp, predominantly due to its nicotine content. The carbon monoxide in smoke decreases the oxygen carrying capacity of the blood. These factors may contribute to poor wound healing after a hair transplant and can increase the chance of a wound infection and scarring. Smoking may also contribute to poor hair growth. The deleterious effects of smoking wear off slowly when one abstains, particularly in chronic smokers, so that smoking puts one at risk to poor healing even after smoking is stopped for weeks or even months. Although it is not known exactly how long one should avoid smoking before and after a hair transplant a common recommendation is to abstain from 1 week prior to surgery to 2 weeks after the procedure.
- **SUN DAMAGED SKIN:** After your transplant, you must still protect your scalp from the damaging rays of the sun. Your new hair makes close observation of your scalp important, as new growths, or skin changes, may be more difficult to see. In addition, if you have a history of skin cancer or sun damaged skin, you should be followed by your dermatologist.
- **INFECTION:** The symptoms of infection include swelling, redness, tenderness or puss at the surgical site and may be associated with fever or chills. If you experience any of these symptoms, contact us at once.
- **OTHER:** There may be temporary swelling, discoloration, or bruising associated with the procedure. There may be the formation of a cyst at a graft site, hematoma (localized blood clot), or rejection of a graft. In areas of scar tissue, grafts may grow poorly or not at all. Infection is rare, an antibiotic will

be given to reduce the incidence of this occurring. The symptoms of infection include swelling, redness, tenderness or puss at the surgical site and may be associated with fever or chills. If you experience any of these symptoms, contact us at once.

**For patients that have had prior hair restoration surgery at another institution:**

\_\_\_\_\_ I acknowledge that prior to contacting Bernstein Medical, P.C., I received Hair Transplants/Scalp Reductions from another physician and the results of these procedures were below my expectations. I further acknowledge that Bernstein Medical, P.C., its physicians and employees bear no responsibility for my present condition. I also acknowledge that I have been informed that Bernstein Medical, P.C.'s physicians may not be able to correct my condition, although they will attempt to do so. (Please initial)

**Consent for an in-house peer review of my medical record:**

\_\_\_\_\_ In the ongoing pursuit of quality patient care, BMPC selects a number of patient medical records for periodic review. I hereby give my consent for BMPC physicians to review my medical record should it be selected. I understand that the information contained in my medical record will be kept strictly confidential at all times.

**Photography:**

\_\_\_\_\_ I understand that routine full face and scalp photographs will be taken for my office file. This consent does not include the use of photographs for advertising. (Please initial)

\_\_\_\_\_ I consent that my photographs may be used for medical, educational, or scientific purposes without my further agreement providing that my name is not revealed on the pictures or in the accompanying text and that images are from the eyebrows-up only. (Please initial)

\_\_\_\_\_ I consent that my photographs may be used on the Bernstein Medical web site without my further agreement providing that my name is not revealed on the pictures or in the accompanying text and that images are from the eyebrows-up only. (Please initial)

**Driving Caution:**

\_\_\_\_\_ I am aware that I will be given medications during and after the surgical procedure that may cause drowsiness and/or impair my judgment. I understand that I will not operate a motor vehicle the day of surgery or at any time while I am under the influence of these medications. (Please initial)

**Consent:**

\_\_\_\_\_ I have had the opportunity, in advance of my procedure, to read the contents of material made available to me by Bernstein Medical, P.C. including the information on the company website [www.BernsteinMedical.com](http://www.BernsteinMedical.com), Dr. Bernstein's medical publications, the surgical consent form, and pre-operative instructions. (Please initial)

\_\_\_\_\_ I am aware that the practice of medicine and surgery is not an exact science and that knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results. I certify that no one has made any guarantee or warranty as to the final outcome or appearance that may be expected. (Please initial)

\_\_\_\_\_ The procedure, its indications, risks and alternatives have been explained to me by my physician, and through the inquiry package, and the preoperative instructions. I recognize that during surgery unforeseen conditions can occur that may alter the course of surgery and necessitate deviating from the original plan. This may include the transplantation of more or fewer grafts than scheduled. I hereby authorize and request the surgeon to use his/her professional judgment to complete the surgery in a manner that will produce the best results in the safest way possible. I have read and understand this consent for surgery. I have been given the opportunity, by my physician, to ask questions, and all of my questions have been answered to my full satisfaction. Any objections have been noted or stricken and initialed by me. (Please initial)

\_\_\_\_\_ I understand that Bernstein Medical, P.C. does NOT adhere to advance directives (living wills). (Please initial)

\_\_\_\_\_ This consent was read and signed by me while I was not under the influence of medications or other substances that can cause drowsiness or impair judgment. (Please initial)

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of physician

\_\_\_\_\_  
Date

I certify that on this date I have observed this patient carefully read and sign this consent form of his/her own free will.

\_\_\_\_\_  
Witness for BMPC

\_\_\_\_\_  
Date