Double Eyelid Surgery

DOUBLE EYELID SURGERY

DisclaimerProcedure Overview Double eyelid surgery (also known as Asian blepharoplasty) is a cosmetic surgical procedure designed to create a defined crease in the upper eyelid, resulting in the appearance of a "double eyelid." The procedure can involve incisional or non-incisional methods, depending on the client's anatomy and aesthetic goals.Intended Benefits Creation or enhancement of an upper eyelid crease Improved eye symmetry and definition A more open, alert, or youthful eye appearance Potential improvement in eyelid heaviness or droopingPotential Risks and Complications As with any surgical procedure, there are associated risks, including but not limited to: Swelling and bruising Asymmetry between eyes Visible or raised scarring Infection or delayed healing Dry or irritated eyes Overcorrection or undercorrection Difficulty closing the eyes fully Temporary or permanent changes in eyelid sensation Unsatisfactory cosmetic result requiring revisionContraindications This procedure may not be suitable for individuals with: Bleeding disorders Active skin infections around the eye Uncontrolled medical conditions (e.g. diabetes, hypertension) Unrealistic expectations about the results Autoimmune conditions affecting skin healing Your suitability will be assessed during the consultation.Pre-Treatment Instructions Avoid blood-thinning medications or supplements (e.g. aspirin, ibuprofen, vitamin E) for at least 7 days before surgery Refrain from smoking and alcohol for 1 week before and after the procedure Remove all eye makeup and contact lenses prior to treatment Arrange for transportation after the procedure if sedation or anaesthesia is usedPost-Treatment Aftercare Apply cold compresses as instructed to minimise swelling Use prescribed eye ointments or drops as directed Sleep with your head elevated for several days Avoid rubbing or touching the eyes Refrain from wearing eye makeup until healing is complete Protect the eyes from sun and wind Attend all follow-up appointments as scheduled Contact your practitioner if you notice excessive pain, bleeding, discharge, or vision changesInformed Consent and Photography I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: the aims/motivations for having the procedure and the desired outcome the risks inherent in the procedure the risks inherent in refusing the procedure the risks specific to me the expected benefits of the treatment the potential disadvantages of the treatment alternative procedures and their pros and cons – including the option of no treatment at all any uncertainties about and the likelihood of success of the procedure any follow-up treatment that may be requiredClinical Photographs and Videos: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records.I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.