Tummy Tuck Revision

TUMMY TUCK REVISION

Status: active Form type: default Company: Acme Inc

DISCLAIMER

Disclaimer Procedure Overview Tummy tuck revision surgery (abdominoplasty revision) is a secondary procedure designed to correct or improve the results of a previous tummy tuck. It may involve the removal of additional skin or fat, correction of scars, muscle tightening, or improving the overall aesthetic contour of the abdomen. Intended Benefits Correction of irregularities, asymmetries, or unsatisfactory results from a prior tummy tuck Improved abdominal contour and symmetry Enhanced satisfaction with the original procedure Potential Risks and Complications As with all surgical procedures, tummy tuck revision involves risks. These may include: Swelling, bruising, pain or discomfort Bleeding or haematoma Infection Delayed wound healing Scarring, including thickened or raised scars Seroma (fluid collection under the skin) Numbness or changes in skin sensation Muscle weakness or separation Need for additional revision procedures Anaesthesia-related complications Contraindications This surgery may not be suitable for clients who: Have significant medical conditions that increase surgical risk Are pregnant or planning pregnancy Are significantly overweight or have unstable weight Smoke or use nicotine products (which impair healing) Your surgeon will assess your suitability during consultation. Pre-Operative Instructions Stop smoking and avoid alcohol at least 2–4 weeks before surgery Discontinue blood-thinning medications or supplements (under medical advice) Arrange for help during the recovery period Follow all fasting and medication instructions provided before surgery Post-Operative Aftercare Wear compression garments as advised to reduce swelling and support healing Avoid heavy lifting and strenuous activity for at least 4–6 weeks Attend all scheduled follow-up appointments Keep incisions clean and dry; follow all wound care instructions Sleep with the upper body slightly elevated to reduce tension on the incision Monitor for signs of infection or complications and contact your clinic if concerned Informed 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 required Clinical 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.