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LABIAPLASTY CONSENT

Excision of excess labia minora tissue and plastic reconstruction, and/or excision of excess clitoral hood and/or surrounding tissue and plastic reconstruction, and/or scar revision and plastic reconstruction of previously operated areas. Procedure may include laser surgery and/or radiofrequency surgery.

I have been told that this procedure may subject me to a variety of discomforts and risks. I understand that I will not be fully recovered from this surgery for approximately 4-6 weeks. Most patients have surgery with little difficulty, but problems can happen ranging from minor to fatal. These include:

- Nausea, vomiting
- Pain,
- Bleeding,
- Infection,
- Poor healing, or formation of fistulas, adhesions or strictures.
- Urinary retention requiring catheter drainage may occur.
- Sexual function may improve following complete healing, but improvement cannot be guaranteed and worsened sexual function is a possibility.
- Unexpected reactions may occur from any drug or anesthetic given.
- Unintended injury may occur to other pelvic or perineal structures such as external and internal anal sphincters, and local nerves or blood vessels.
- Any such injury may require immediate or later additional surgery to correct the problem. Dangerous blood clots may form in the legs or lungs.
- Physical and sexual activity will be restricted in varying degree for an indeterminate period of time, but most often 3-6 weeks.

Finally, I understand that it is impossible to list every possible undesirable effect and that the condition for which surgery is done is not always cured or significantly improved, and in rare cases may even be worse.

The procedure has been explained in terms understandable to me, which explanation has included:
a. The purpose and extent of the procedure to be performed.
b. The risks involved in the proposed procedure, including those, which, even though unlikely to occur, involve serious consequences.
c. The possible or likely results of the proposed procedure.
d. The feasible alternative procedures and methods of treatment.
e. The possible or likely results of such alternatives.

f. The results likely if I remain untreated.

I have had sufficient opportunity to discuss my (the patient's) condition and treatment with the doctor and/or his associates, and all of my questions have been answered to my satisfaction. I believe that I have had adequate knowledge upon which to base an informed consent to the proposed treatment

I consent to the performance of additional operations and procedures different from those contemplated and deemed necessary or advisable during the course of the authorized procedure because of unforeseen conditions. The authority under this paragraph shall extend to all conditions that require treatment but were not known to the named doctor, at the time the procedure commenced.

I consent to the administration of anesthesia and/or conscious sedation as may be deemed advisable by, or under the direction and supervision of, the physician responsible for this service. The risks, alternatives, and benefits have been discussed.

I consent to the retention or disposal of any tissues or parts, which may be removed.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND, AND CONSENT TO THE ABOVE PROCEDURE(S), THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE.

Patient's Name (PRINT)	Date
Patient's Signature	
Witness Name (PRINT)	Date
Witness Signature	
Surgeon's Signature	Date