THE REED CENTRE
for Ambulatory Urological Surgery
1111 KANE CONCOURSE
BAY HARBOR ISLANDS, FLORIDA 33154
Phone (305) 865-2000 / Fax (305) 865-2002

INFORMED CONSENT FOR SUBCUTANEOUS MASTECTOMY (FEMALE TO MALE CHEST)

1. I hereby request and authorize Dr. Harold M. Reed, assisted by his designated personnel to perform the operation entitled "Subcutaneous Mastectomy" in an effort to remove female breast tissue and reduce nipple areolar-complex size.

2. Dr. Reed has discussed his case experience with me but has not made any promise of a specific performance or guaranteed either expressly or by implication a result.

3. The incisional approach will vary depending upon the amount of breast tissue and skin to be removed and will leave recognizable scars, which will fade with time to some degree, but also will be to some extent persistent.

4. Jackson-Pratt type drains will be installed postoperatively and will be removed 3 to 5 days later when drainage becomes minimal.

5. Crusting of the nipple-areolar complex is to be expected after surgery and there is a remote possibility that this complex may undergo necrosis.

6. Post-operative swelling of some areas of the breast may last up to six weeks.

7. To preserve a normal and healthy appearance of the skin, some amount of subcutaneous fat will remain.

8. Patches of induration or firmness under the nipple or areola (the pigmented area around the nipple) may occur as a reaction to this procedure and usually resolves over a period of a few months.

9. If applicable, I have discussed this procedure with my sexual partner or "significant other" and have gained their approval, or after careful consideration of my situation and relationship have decided to proceed.

10. I will not sun bathe for at least 6 weeks.

11. I have abstained from smoking for 2 weeks prior to this procedure and will abstain for 2 months following this procedure.

12. Additional complications of this procedure include pain or discomfort, neural and

vascular injury, separation of incisional margins, black and blue bruising, irregular contours, asymmetrical results, areas of firmness to touch, collections of blood or serum under the skin, bleeding with excessive blood loss, inadequate resection, need to terminate procedure prior to complete resection, and the remote possibility of cardio-pulmonary and central neurological events. I can appreciate that with any surgical procedure there may be unforeseen complications as well.

13. I will call Dr. Reed immediately if there are any concerns and keep my follow-up appointments with him. (305) 865-2003.

14. The patient consents to medical photography before, during, and after treatment, and that these photographs become the property of Dr. Harold M. Reed, and may be utilized for but not limited to publication in scientific journals, or presentation in a manner related to medical practice.

15. I have been given a choice of anesthesia and also anesthesia providers, i.e. anesthesiologist versus CRNA versus certified P.A. The administration of anesthesia, should an anesthetist or anesthesiologist be used, the administering is an independent function and any questions regarding anesthetic management should be addressed directly to the anesthetist. A remote complication of general anesthesia is inadequate intubation, and a remote complication of local anesthesia with IV sedation is inadequate pain control.

16. The maintenance of personal hygiene is important in preventing post-op infection.

17. I am aware that Dr. Harold Reed has elected under the provisions of Florida State law not to carry professional liability insurance.

18. I am aware following this procedure I will need to wear a constriction garment vest to reduce swelling and abdominal binder (if applicable) post-operatively.

19. I can appreciate that subcutaneous mastectomy is an irreversible procedure and have received letters of therapy clearance for this procedure.

19. I have had ample opportunity to discuss the intended procedure with Dr. Reed and he has answered any questions that I might have.

I have read and signed the above consent in the presence of a witness whose signature appears below, after I have had an opportunity to question Dr. Reed regarding any unfamiliar medical terminology.

Dr. Reed has a proprietary interest in this CENTRE. You may wish to consider alternative sites for evaluation and treatment.

Pursuant to statue 64B8-9.0091, (FAC), this surgical facility is not operating as an ambulatory surgical centre (ASC) for the purposes of this consent.

DATE:_____TIME:_____

PATIENT NAME:_____

WITNESS:_____

I have personally discussed with the patient the above described proposed surgery, its risks and potential complications, as well as the alternatives available.

_____
HAROLD M. REED, M.D.
(conmastectomy)