All About Aesthetics, PC
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Consent for Surgery and Administration of Anesthetics

Patient:_____Date:_____

DOB:_____Location: Office / Hosp:_____

I authorize Deborah Kessler Hudak, MD to perform the following procedure(s):
__Blepharoplasty of Rt eye upper/ lower lid(s), Lt eye upper/ lower lid(s)
__Blepharoptosis Repair of Rt/ Lt upper lid(s) by Levator Aponeurosis Resection/ Sling
__Mid-face Lift to Rt/ Lt face , including/ excluding neck lift
__Brow Lift Rt/ Lt, __mid-coronal / __direct/ __high coronal
__Lateral Tarsal Strip Procedure, Rt/ Lt lower lid
__Medial Spindle Procedure, Rt/ Lt, Upper/ Lower Lid
__Pentagonal Wedge Resection, Rt/ Lt upper/ lower lid
__Full-thickness Skin/ Myocutaneous Graft from_____to_____
__Probe and Irrigation of the Nasolacrimal Duct System, Rt/ Lt, Upper/ Lower
__Stent placement to Nasolacrimal Duct System Rt/ Lt, Upper/ Lower lid(s)
__Punctal Plug placement, Rt/ Lt, upper/ lower lid(s)
__Cautery to punctum, Rt/ Lt, upper/ lower lid(s)
__Incision/ excision of skin lesion with/ without pathology, Rt/ Lt, lid, upper/ lower, face_____
__Incision and drainage of Chalazion/ abscess Rt/ Lt, upper/ lower lid(s)
__Epilation/ electrodestruction of lashes Rt/ Lt, upper/ lower lid(s)
__Excision/ biopsy of orbital mass lesion, Rt/ Lt eye
__Other_____
_____
Reason for surgery: blepharochalasis/ ptosis/ rhytids/ skin laxity/ frontalis atrophy/ ectropion/ entropion/ skin mass/ scar/ skin defect/ epiphora/ dacryocystitis/ dry eye/ chalazion/ abscess/ trichiasis/ orbital mass/ other_____

I understand the risks and alternatives to the procedure(s), including loss of blood, risk of infection, bruising, swelling, tearing, pain, dry eyes, hematoma, redness, over-correction, under-correction, lid droop, lid retraction, scarring, keloid, double vision, loss of vision, loss of eye, allergy reaction to medications or sutures used, death of skin._____
I understand that during the procedure, unexpected conditions may occur that require additional surgery, and I authorize Dr. Hudak and her assistants to perform such procedure(s) if medically indicated._____
I consent to the administration of anesthetics under Dr. Hudak's direction._____
I consent to the taking of pictures, when recommended._____I consent to their use in Dr. Hudak's photo album_____ website_____
I understand there are no guarantees concerning the surgery and I feel I am making a well-informed decision.

Patient_____Witness_____Date_____