AIAVS
ALINSOD INSTITUTE
for AESTHETIC VULVOVAGINAL SURGERY

TODAY'S DATE: _____

PATIENT'S NAME:

_____

DOB: _____

ACCOUNT#_____

SURGICAL INFORMED CONSENT

PRE-OP NOTE: Surgical Risks/Benefits/Options have been fully discussed and Questions answered

SURGERY: I request the following surgery(ies) and/or procedure(s) to be performed by Dr. Alinsod and his assistants: (**Please initial** surgery(ies) and/or procedure(s) requested or recommended, indicated by mark or highlighter)

GYNECOLOGIC SURGERY:

____ Suburethral Sling (TOT/TVT),
____ Cystoscopy
____ Anterior Repair, Paravaginal Repair ____ Mesh ____ Biologic ____ Native
____ Posterior Compartment Repair ____ Mesh ____ Biologic ____ Native
____ Enterocele Repair ____ Mesh ____ Biologic ____ Native
____ Vaginal Vault Suspension ____ Mesh ____ Biologic ____ Native
____ SSLS (Sacro-Spinous Ligament Suspension)
____ PIVS (Posterior Intra-Vaginal Slingplasty)
____ Uterine Suspension
____ Cystectomy
____ Urethral Dissection
____ Band Release

____ Hysteroscopy ____ Endometrial Biopsy
____ Endometrial Resection ____ Endometrial Ablation
____ Polypectomy ____ Myomectomy
____ Dilatation and Curretage
____ Cystoscopy with Hydrodistention ____ Cystoscopy with Bladder Botox

____ Other_____
_____

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

____ THESE PROCEDURES DOES **NOT** APPLY TO ME.

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

TODAY'S DATE: _____

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SURGICAL INFORMED CONSENT

AESTHETIC VAGINAL SURGERY

____ Labia Minora Plasty ____ Curvilinear ____ Wedge ____ Labia Minora Revision
- ____ Barbie Appearance
- ____ Rim Appearance
- ____ Hybrid
- ____ No preference

____ Labia Majora Plasty
____ Clitoral Hood Reduction/Contouring
____ Vaginoplasty
Tightness to approximately:
_____ "**one** finger" _____ "**two** fingers" _____ "**three** fingers"

____ Labia Majora Revision
____ Clitoral Hood Reduction Revision
____ Vaginoplasty Revision

____ Perineorrhaphy/ Perineoplasty
____ External Hemorrhoidectomy/Anal Tag Removal

____ Perineorrhaphy/ Perineoplasty Revision
____ Hemorrhoidectomy/Anal Tag Revision

____ Skin Resurfacing AREA: _____
____ Resuturing AREA: _____

____ Hymenoplasty

____ PRP/Amniotic Fluid Injection ____ G-Spot/Clitoral/Periurethral (aka O-Shot)

____ Vampire Wing Lift of the Majora with PRP and Hyaluronic Acid

____ Radiofrequency Treatments of Vulvovaginal Areas (Internal and/or External)

____ Other_____

ADDITIONAL PROCEDURES: I understand that:
____ NO PROCEDURES CAN BE ADDED ON THE DAY OF SURGERY IF MEDICATED
____ Additional surgery(ies) / procedure(s) should be requested NO LATER THAN **FIVE (5) DAYS** PRIOR to my scheduled surgery date.

(NOT APPLICABLE IF CONSULTATION AND SURGERY ARE SCHEDULED FOR THE SAME DAY)

I have chosen my location of surgery to be:
____ Office Procedure Room
____ Surgery Center

PATIENT SIGNATURE: _____ _____/_____/_____ (DATE) ____:_____ (TIME)

____ THESE PROCEDURES DOES **NOT** APPLY TO ME.

PATIENT SIGNATURE: _____ _____/_____/_____ (DATE) ____:_____ (TIME)

REVIEWED_____

TODAY'S DATE: _____

PATIENT'S NAME:

_____

DOB: _____

ACCOUNT#_____

SURGICAL INFORMED CONSENT

____ **QUESTIONS:**

- I have had a chance to ask all the questions on the surgery(ies) / procedure(s)
- I have requested and have been satisfied with the answers given.
- I understand what I am having done and the extent of the surgery(ies) / procedure(s) provided.
- I am aware that I am free to ask questions at any time. Contact information has been provided to me. I have no further questions at this time.

____ **BENEFITS OF SURGERY**:

The benefits have been fully disclosed and I completely understand them.
They include:

- Improved comfort
- Possibly less pain and discomfort

Pelvic surgery may also relieve:

- Abnormal bleeding / Heavy Bleeding
- Pressure / Heaviness / Fullness
- Other symptoms such as urinary and bowel dysfunction

____ **AESTHETICS:**

- Improved comfort
- A more pleasing appearance
- Confidence in personal appearance

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

REVIEWED_____

TODAY'S DATE: _____

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_____

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SURGICAL INFORMED CONSENT

RISKS SPECIFIC TO GYNECOLOGIC SURGERY: Please Initial
The risks have been fully disclosed and reviewed by me and I completely understand and accept these risks including but not limited to the following:

____ Anesthesia
- · Aspiration
- · High temperature
- · Rash
- · Difficulty breathing
- · Anaphylaxis
- · Infection
- · Incomplete anesthesia
- · Throat Discomfort
- · Unknown reaction to anesthetics

  - **I HAVE CHOSEN MY ANESTHESIA TO BE:**
    ____ Topical/Local with mild sedation by injections
    ____ Spinal or epidural
    ____ General Anesthesia

____ Infection
- · Need for wound cleaning
- · Wound drainage
- · Antibiotics

____ Bruising, Bleeding/Hemorrhage from vessel damage or clotting problems and the possibility of needing transfusion of blood products or fluid expanders.
  - Related risks of transfusion:
    - · Anaphylaxis
    - · Shock
    - · Hepatitis
    - · HIV
    - · Other unknown organisms

____ Blood clots in the pelvis, lungs, or brain with a need for blood thinners or surgery.

____ Hematoma formation with need for evacuation of large or growing hematomas and the possibility of needing drains.

-List continues on page 5

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

REVIEWED_____

TODAY'S DATE: _____

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_____

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SURGICAL INFORMED CONSENT

-List continued from page 4

____ Damage to internal organs with need for repair or revision
- Bowel: perforation, blockage
- Bladder: perforation, tears, mesh erosion, suture in bladder
- Ureters: occlusion, kinking, transection
- Urethra: occlusion, kinking, perforation, deviant urine flow, urinary retention

____ Hernia formation from surgical sites or recurrence of lesions.

____ Nerve damage
- Loss of sensation or reduced sensation
- Hypersensitivity
- Irritation
- Pain
- Loss of muscle control

____ Suture breakdown and/or rapid suture autolysis and possible need for placement of new or different sutures.

____ Prolonged catheterization or difficulty in emptying bladder may occur; an indwelling catheter may be used, and the possibility of urinary retention was also discussed and accepted.

____ Incontinence may occur or get worse from pelvic prolapse repairs.

____ Urge symptoms to urinate may occur.

____ I understand further procedures or surgeries may be needed in the future for
· revision · repair · removal · scar reduction · band release

____ No guarantees have been implied and/or given to the patient regarding the safety and efficacy of the procedure nor has any guarantees been implied and/or given in regards to results.

____ Surgery may fail and may need to be redone.

____ Death is a possibility with any surgery.

PATIENT SIGNATURE: _____ _____/_____/_____ ____:_____
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_____

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SURGICAL INFORMED CONSENT

RISKS SPECIFIC TO AESTHETIC VULVOVAGINAL SURGERY: Please initial

____ Improper or unappealing healing with wound edges not perfectly aligned, scalloping of edges, including asymmetric healing where one side may be more or less prominent than the other side

____ I understand that every individual heals differently

____ I understand that retraction of edges may occur and that even a Rim appearance Post-Op may retract into a Barbie appearance later on

____ I understand that variable blood supply may hamper proper healing, wound breakdown may occur

____ I understand that activities I perform may damage my surgical repair and that strict adherence to my post-op instruction is critical

____ I understand that I am not allowed to have sexual relations and I will not engage in sexual activity for at least six (6) weeks; until cleared by Dr. Alinsod

____ I understand that scarring from reaction to sutures, infections, keloids may occur and that all scars may not be hidden from view or may actually be more prominent depending on the healing process

____ I understand wound revision(s) or resurfacing procedure(s) may be needed to achieve the desired look and appearance

____ I understand that Dr. Alinsod performs revisions for $1,500 **within one (1) year** of his original surgery to cover OR fees. He does not charge a professional fee.

____ I understand that consultations and revisions performed by other surgeons are my financial responsibility

____ I understand that revisions may not be able to accomplish the cosmetic/functional goals I am seeking

____ I understand that post-operative visits are crucial and Dr. Alinsod cannot be held responsible if he is unable to evaluate my progress

____ I fully understand that Dr. Alinsod does not guarantee that he will be able to achieve the results I am seeking. No guarantees have been implied or given.

-List continues on page 9

PATIENT SIGNATURE: _____ _____/_____/_____ ____:_____
DATE **TIME**

TODAY'S DATE: _____

PATIENT'S NAME:

_____

DOB: _____

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SURGICAL INFORMED CONSENT

-List continued from page 8

____ I fully understand the ramifications of a vaginoplasty that is too tight (i.e. painful intercourse, scars and bands inside the vagina, and the need for revision) and that diligent vaginal softening exercises will be needed to be performed from two (2) weeks to a month or more starting at about the sixth (6^{th}) week Post-Op depending on the size desired. Band release may also be needed.

____ I fully understand that hymenoplasty may result in painful intercourse initially with the possibility of bleeding and hemorrhage. It is also possible that I may not bleed.

I also understand that the hymen may need to be incised to release retained fluids or for comfortable intercourse. No guarantees of bleeding during sex are given.

____ I have reviewed all information and I understand that no guarantees have been implied and/or given to me regarding the safety and efficacy of the procedure(s); nor have any guarantees been implied and/or given in regards to results.

DISCLOSURE:

Dr. Alinsod and his staff have given me full disclosure regarding my surgery. I have received and read the following in regards to the above medical and/or aesthetic vaginal surgery(ies) and/or procedure(s):

____ Photo and Video Consent (Attached)
____ Mesh Information Handout
____ Bowel Preparation Handout (Attached)
____ Pre-Op and Post-Op Instructions (Attached)
____ Training Day Consent (Attached)
____ Other:_____

OPTIONS: Please initial

____ The options of care have been fully discussed. I have had the chance to research other surgeons and surgical approaches and am aware of my options such as:

- outside consultations
- surgery or no surgery
- expectant management (wait and see)
- medical management or
- to proceed with the agreed upon surgery(ies) / procedure(s).

____ I have elected to proceed with the surgery(ies) / procedure(s) willingly and without hesitation at the time frame of my choice; I am also aware that I reserve the right to cancel surgery(ies) / procedure(s).

PATIENT SIGNATURE: _____ _____/_____/_____ ____:_____
DATE **TIME**

TODAY'S DATE: _____

PATIENT'S NAME:

_____

DOB: _____

ACCOUNT#_____

SURGICAL INFORMED CONSENT

OTHER CONCERNS AND DISCUSSIONS:

_____

_____

I understand **THIS IS A LEGAL DOCUMENT** that is beneficial for all parties involved and that it requires my signature of authorization, consent and acknowledgement.

Dr. Red Alinsod, South Coast Urogynecology, Inc. and/or his employee(s) reserve the right to refuse proceeding with the surgery(ies) / procedure(s) if I refuse to sign this document.

My signature below acknowledges that all Risks/Benefits/Options have been fully discussed and explained to me; I have received and reviewed all Pre-Op and Post-Op Instructions with Dr. Alinsod and/or his employee(s). I understand and accept all information, consents and instructions provided to me in its entirety. I am aware that a copy of this signed consent is available to me upon request.

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

PATIENT PRINTED NAME: _____

PHYSICIAN SIGNATURE: _____ _____/_____/_____ _____:_____
Red M. Alinsod, M.D., FACOG, FACS, ACGE **DATE** **TIME**

WITNESS SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

WITNESS PRINTED NAME: _____

REVIEWED_____ **DATE** _____ **TIME** _____

NO CHANGES _____ **CHANGES** _____

In conjunction with this surgery(ies) / procedure(s) I have received:

- _____ Prescriptions required prior to surgery and post-operatively
- _____ Numbing Cream
- _____ Collagen Cream
- _____ Estrace Cream

TODAY'S DATE: _____

PATIENT'S NAME:

_____

DOB: _____

ACCOUNT#_____

PHOTOGRAPHY AND VIDEO CONSENTS

SURGICAL DOCUMENTATION

____I **AUTHORIZE** Dr. Alinsod and his Staff to take photographs or videos of my surgical procedure(s) and/or treatment. This includes:

- Pre-Operative / Pre-Treatment
- Intra-Operative / Intra-Treatment
- Post-Operative / Post-Treatment and
- Patient Chart Management

I understand that the photographs and videos are for documenting the surgery and evaluating the results of surgery. I understand that the digital photographs will be stored securely on Dr. Alinsod's computers and charts with full HIPPA Regulations followed.

_____ _____/_____/_____ ____:____
Signature Date Time

_____
Printed Name

_____ _____/_____/_____ ____:____
Witness Date Time

EDUCATIONAL AND MARKETING USES

Please **Initial ONE**:

____I **AUTHORIZE** Dr. Alinsod to use my photographs or videos for educational and marketing purposes (various media outlets such as print, CD/DVD, or internet) in an anonymous manner and with complete confidentiality. There will be no identifying marks seen or portrayed unless approved by me. If I change my mind, I will notify Dr. Alinsod and/or his staff. I am aware that authorized use is uncompensated.
Facial photos ____ Full face ____ Sections only (please specify, i.e. eyes, mouth, full side view)

____I **DECLINE** to have my photographs or videos used for educational or marketing purposes. If I change my mind, I will notify Dr. Alinsod and/or his staff.

_____ _____/_____/_____ ____:____
Signature Date Time

_____
Printed Name

_____ _____/_____/_____ ____:____
Witness Date Time

TODAY'S DATE: _____
PATIENT'S NAME:
_____
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ACCOUNT#_____

TRAINING DAY CONSENT

I, _____, understand that the procedure(s) consented to on the
Patient Name
Surgical Informed Consent, will be performed on a Training Day.

The training will be held at:
____Office Procedure Room
____Surgery Center

The persons to be present will be:
- Dr. Red Alinsod, who will be performing the surgery.
- Office, Hospital or Surgery Center staff, depending on the location.
- Visiting doctor or doctors, for observation only.
- Visiting doctor or doctor's staff, for observation only.
- Medical device representative, for support and observation only.

The above persons will be present before, during and after the procedure(s) already consented to, on the Surgical Informed Consent.

_____ _____/_____/_____ ____:____
Signature Date Time
_____
Printed Name

_____ _____/_____/_____ ____:____
Witness Date Time
_____
Printed Name