

## **CONSENT FOR ABDOMINOPLASTY (TUMMY TUCK SURGERY)**

Patient Name: \_\_\_\_\_

Age / Sex: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

### **1. Nature of Procedure**

I understand that Abdominoplasty (Tummy Tuck) is a surgical procedure performed to remove excess skin and fat from the abdomen and to tighten the abdominal muscles for improved contour.

### **2. Anaesthesia**

I understand that the procedure will be performed under:

- General Anaesthesia / Epidural Anaesthesia
- I have been explained the risks and benefits of anaesthesia.

### **3. Pre-operative Instructions**

I agree that:

- I will undergo all necessary blood tests and investigations before surgery.
- I will follow fasting instructions (usually 6–8 hours before surgery).
- I will inform the doctor about all medications, allergies, and medical conditions.

### **4. Risks and Complications**

I understand that although care is taken, complications may occur, including:

- Pain, swelling, bruising
- Infection
- Bleeding or hematoma
- Seroma (fluid collection)
- Scarring
- Delayed wound healing
- Asymmetry or unsatisfactory cosmetic result
- Need for additional procedures

## 5. Post-operative Care

I understand that:

- I may need to stay in the hospital for 1–2 days.
- Drain tubes may be placed temporarily.
- Compression garments must be worn as advised.
- Physical activity will be restricted for a few weeks.
- Follow-up visits are essential.

## 6. Recovery Expectations

- Initial recovery: 2–3 weeks
- Complete healing: may take several months
- Final results vary from person to person

## 7. Alternatives

I understand that alternative treatments (including no surgery) have been explained to me.

## 8. Consent Statement

I confirm that:

- The procedure, risks, benefits, and alternatives have been explained to me in a language I understand.
- I have had the opportunity to ask questions, and all my questions have been answered satisfactorily.
- I voluntarily consent to undergo Abdominoplasty Surgery.

## Signatures

Patient / Attender Signature: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Place: \_\_\_\_\_