

Consent to Hair Transplant Surgery (Template)

Patient's Name: _____ Patient's Date of Birth: _____

Medical Record No. : _____ Name of Responsible

Physician: _____

I. Surgery to be implemented (please add a brief explanation for any complicated medical term)

1. Recommended Surgery (Site):

2. Recommended Reason for the Surgery:

(please note the specific side for the part with difference of left and right)

II. Statement of the Physician (please mark "V" for an item that has been notified to the patient and "X" for an item that hasn't been notified to the patient)

1. I have tried my best to explain the information relevant to the surgery in a way that the patient can understand, particularly involving the following items:

- Reason for the surgery, steps, range, risk and success rate of the surgery and possibility of blood transfusion
- Surgical complications and possible treatments
- Possible consequence of not implementing the surgery and other alternative treatments
- Any temporary or permanent symptom that may occur after the surgery
- I have delivered the additional surgery-related descriptive information the patient if any

2. I have left sufficient time to allow the patient to ask questions related to the surgery and have answered the questions too:

- (1)
- (2)
- (3)

Signature of the Physician Responsible for the Surgery:

Date: _____

Time: ____ (h) ____ (m)

III. Statement of Patient

1. The physician has explained to me and made me fully understand the information relevant to necessity, steps, risk and success rate of the surgery.
2. The physician has explained to me and made me fully understand the risks of other alternative treatments.
3. The physician has explained to me and made me fully understand the possible prognosis of the surgery and the risk of not implementing the surgery.
4. I've understood blood transfusion may be necessary during the surgery; I agree disagree with **blood transfusion.**
(Except for an emergent case as specified in Article 63 of the Medical Care Act.)
5. I have put up my questions and doubts regarding my condition, the surgery and treatment etc. and received replies.
6. I understand in case it is necessary to incise an organ or tissue during the surgery, the organ or tissue may be kept for a period of time in the hospital for the purpose of pathological analysis and report and the organ or tissue will be disposed discreetly as per relevant laws and regulations by the hospital.
7. I understand the surgery may be the most appropriate option at present but it cannot be ensured that the surgery would improve my condition definitely.

I agree with implementation of the surgery based on the statement above.

Signature of the Consenter:

Relation with the Patient: _____

Tel: (0) _____

Address:

Date: _____

Time: ____ (h) ____ (m)

Signature of the Witness:

Witness is unnecessary, Signature:

Date: _____

Time: ____ (h) ____ (m)

Remarks: _____

I. General Surgical Risks

1. Except for surgeries with local anesthesia, a small part of lungs may collapse and lose function during a surgery, resulting in an increase of the possibility of chest infection, which may require antibiotics and respiratory therapy.
2. Surgeries except for those with local anesthesia may cause vascular embolization accompanied by pain and swelling in legs. And coagulated blood clots may disperse and enter into lungs, causing a deadly danger; but such situation is not common.
3. Since the heart is under stress during a surgery, a heart disease or stroke may be induced.
4. Medical institutions and medical staff will try their best to provide a treatment and surgery to a patient; but the operation will not be necessarily successful and an accident that may even cause death still might happen.

II. The patient shall sign the field of "Signature of the Consenter" personally; but if the patient is a minor or unable to sign in the field personally, the person provided in Item 2, Article 13 of the Medical Care Act shall sign in the field <The Civil Law provides: an adult is a person whose age is 20 or above.>.

III. In case the consenter is not the patient, the relation between the consenter and the patient shall be filled in the field of "Relation with the Patient".

- IV. As for the witness, the field may be left blank when there isn't any witness; but the box in front of "Witness is unnecessary" should be ticked and the person who ticks the box should leave a signature.
- V. **Any medical activity relevant to a plastic or cosmetic surgery that is not necessary medically must not be executed for minors under the age of eighteen in accordance with Item 4.1 of Article 28, Physicians Act of Republic of China, Taiwan.** °

Description of Hair Transplant Surgery (Template)

The description is used to explain **your conditions** and the **purpose, method, benefit, possible complications, success rate and alternatives** of hair transplant surgery, **possible problems during recovery and possible consequences without implementing the surgery**, which can be used as reference for discussions between patients and physicians. We hope you would understand the medical procedure fully and if you still have any doubt about the medical procedure after your physician has explained it to you, please discuss with your physician fully before you sign on the consent. We believe your physician would be very glad to answer your questions.

I ‣ Patient's Conditions: insufficient hair may be caused by a congenital factor or acquired injury or another factor.

II ‣ Purpose & Benefit: to improve the quantity and appearance of hair.

III ‣ Method: hair transplant surgery means a surgery will be used to incise and transplant scalp and hair follicles in the area with more hairs to improve the quantity of hair.

IV ‣ Expected Result: improvement of aesthetic effect and creation of a younger look.

V ‣ Possible Complications, Probability of Sequelae and Treatments:

Every surgery has its particular risk; so it is very important to understand the possible risks relevant to hair transplant surgery. The choice of surgery is a result of judgment and weighing on all risks and benefits of a surgery. Although most patients haven't undergone the following complications, the patient who's going to accept the surgery should discuss with your physician about all possible risks and fully understand the consequences of various kinds of hair transplant surgery.

1. Drug-induced nausea /vomiting.
2. Bleeding (lower than 5%).
3. Infection (lower than 1%)
4. Excessive swelling of the scalp.
5. Temporary headache.
6. Temporary paralysis of the scalp.
7. Poor vitality of hair transplanted.
8. Syncope (less than 1%) or dizziness.
9. Cystis caused by hair transplant (less than 1%).
10. A wide and obvious scar in the area of hindbrain where hairs are taken.
11. Bruise.
12. Other rare complications: cheloid, fail of growth of all transplanted hairs, persistent headache, persistent paralysis of scalp, falling of all transplanted hairs, allergy or reactions caused by relevant medication etc..

VI ‣ Alternative to Hair Transplant Surgery: periwig.

VII ‣ Risk without Implementation of the Surgery: no. But the original appearance remains.

VIII ‣ Possible problems during postoperative recovery period:

1. Hematoma: do not bow or do something hard to prevent hematoma due to rise of blood pressure or congestion.
2. Poor wound healing: do not take any irritating food such as pepper and alcohol etc.. Avoid smoking or second-hand smoking. And keep a normal lifestyle to prevent poor wound healing. The wound needs dressing change on time.
3. Scar: the scar when the wound is healed will present pink. The scar can be covered as long as hairs in the area for transplant are 2.5 cm long or longer.
4. The physician will schedule revisit and removal of stitches. And the patient should seek medical treatment as soon as possible in case of significant bleeding, serious pain, local irritation or discomfort.
5. The quantity and location of hair falling are unpredictable in the future. Although the result of hair transplant surgery cannot persist for the whole life; hairs transplanted commonly exist for a long time and seldom fall within 1 to 10 years after the surgery.
6. Temporary hair falling may appear in the hindbrain or around the area where hairs are transplanted, which is hair falling during resting phase and the hair will grow again in 3 - 6 months generally.

IX - Supplementary Description:

1. The patient should inform her physician if she meets any one of the following conditions:
 - 1) Likely to suffer from blood coagulation dysfunction.
 - 2) Suffering from a chronic disease such as diabetes, hypertension, heart disease and vascular sclerosis
 - 3) Likely to suffer from scar hyperplasia
 - 4) Taking medicines that may affect blood coagulation such as Aspirin, Vitamin E and Warfarin etc.
 - 5) Smoking and drinking
 - 6) Allergic to some drug
 - 7) Having accepted a surgery before
2. As smoking may inhibit bloodstream of skin and affect wound healing accordingly; it would be better for a smoker to quit smoking for one month prior to accepting such surgery.
3. A patient who is taking any anticoagulant drug should discuss with her internist about the feasibility of stopping taking such drug for 1 - 2 weeks since such drug may cause a disturbance of blood coagulation and affect wound healing.

X - Questions from the Patient and Her Family:

1. _____
2. _____
3. _____

Patient (or Family/ Legal Representative): _____ (Signature & Seal)

I have understood the description stated above and agree to accept the hair transplant surgery (please sign on the Consent

to Hair Transplant Surgery).

I have understood the description stated above and disagree to accept the hair transplant surgery.

Relation with the Patient: _____(Required)

Physician for Explanation: _____(Signature & Seal)

Date & Time: