Pacific Hair INSTITUTE, INC

**Robert Michael Elliott, M.D., FAACS**
*Diplomate, American Board of Hair Restoration Surgery*

# Consent for Hair Transplant Surgery

1. I hereby grant permission for Robert Michael Elliott, M.D. to perform suitable surgical procedures and to administer local anesthesia, pre-operative inhalation analgesia, and muscle relaxants, antibiotics, and other medications as he deems necessary for treatment of my hair loss.

   I have read and understand the following general definitions of hair restoration procedures:

   HAIR TRANSPLANTATION, related medical terms:

   Donor Area: Grafts are harvested from the donor area located on the back and sides of the scalp.
   Hair Density: Individuals vary considerably in the density of the hair in the donor area. Hair density is determined by the closeness of follicles to one another, not by the texture or caliber of the hair.
   Graft Size: the doctor creates a strip of donor tissue that is then divided into grafts by the technicians. This approach uniformly produces grafts of the highest quality. All follicles are used. In some cases, follicles are individually extracted.

2. I understand that the treatment of my hair loss may require 1-3 sessions in each area of hair loss. I further understand that the doctor may vary the order of these procedures to achieve the optimum results and to fit in with my schedule and appearance requirements.

3. I understand that the doctors employs certified surgical technologists, and medical assistants who will perform some of the technical aspects of the procedures under the doctor direct supervision. The certified surgical technologists and medical assistants will provide placement of the grafts to be subsequently adjusted by the doctor. Any of the persons may remove my sutures post-operatively on the instruction of the doctor. I understand that all surgical cutting, design, and layout of grafts are done exclusively by the doctor.

4. The procedure has been explained to me by the doctor. I have read and understand the Patient Information Booklet, and I completely understand the nature and consequences of the procedure. The following points were specifically made clear:

   a) A scar will always result where an incision is made, but every effort is made to make the scar as inconspicuous as possible. Occasionally, there may be superficial crusting, pinkness, or redness of the incision line temporarily. If a patient has very loose skin, skin that heals poorly, or in a few revision cases, the scar may widen over time. I understand that if I have had numerous hair transplants elsewhere which have resulted in multiple scars throughout my donor area, I can expect a wider scar if it is necessary to take donor through this old scarred area. I understand that the blood supply is limited and the healing will be less than optimal in areas where there is old scarring, and I am more likely to have a permanent area of non-feeling on the scalp. I understand that every effort will be made to take donor from areas that are not already scarred up to minimize the above. This may also occur when several years have elapsed since my last hair transplant.

   b) The same complications may follow this cosmetic surgical procedure as may follow any other type of surgical procedure. These include the following complications which rarely occur: Inflammation, infection, excessive scar tissue, wide scar, permanent loss of feeling in the scalp of the crown head, allergy to suture material, foreign body reaction, blood vessel reaction, dermoid cyst formation, allergy to medications, and loss of pigment of grafts. More common complications would be an area of permanent loss of feeling on the crown of the head due to failure of nerves to grow back to this area, or wider scarring in the case of limited blood supply to my donor area.

   c) Following the procedure, I may expect some degree of swelling and possibly some discoloration or bruising temporarily. I understand that I could have swelling similar to or more than this photo for 2 to 5 days post-op and that I must sleep with my head elevated, up on 5 pillows for 5 nights, to help prevent swelling.

5. I understand that Male or Female Pattern Baldness is a progressive disorder which may start at an early age and progress throughout life. Therefore, I understand that the doctor has made his best estimate of my future pattern based on family history and other factors, but it is impossible to determine exactly how far it will progress. Therefore, I may require additional procedures, if it progresses much farther than anticipated. I further understand that it is important not to start these procedures at too young an age, or if starting young, to be very conservative in the

hair restoration process. I understand that, if I am losing hair slowly, it is best to replace my hair slowly (over a few years to match the rate of natural hair loss).
I agree to work with the doctor in locating the hair lines or other factors according to his advice so it will not be too low or in an inappropriate place. I understand that the interval between hair transplant procedures is usually 6-8 months. This is to allow time for the skin to remodel and smooth itself, and for hair to grow out. Healing rates vary, so my interval could be more or less. Usually, 1-3 transplant sessions are needed in any one area, depending on the density I desire. For example, 1-3 sessions are needed for the hairline, the top, and the crown. However, hairline, top, and crown may be transplanted simultaneously. I further understand that, as hair loss progresses, future touch-up sessions may be needed to fill new areas of hair loss surrounding the previously transplanted area. I acknowledge that hair restoration is an art form, and thus cannot be properly judged until it is completed. Therefore, I agree that I will not achieve final results until I have completed ALL of my treatment plan, including any additional procedures I may require for touch-up or additional hair loss on my part, and the hair has all grown for 1-2 years. I understand that the treatment plan is 1-3 session in each area depending on the density desired, plus touch-ups at 1 and 2 years, plus an additional 1-3 sessions in any area of additional hair loss.

6. I have read my post-operative instructions and I will follow them closely.
7. I understand that numbness may occur temporarily on the scalp and is the result of the cutting and cauterizing of nerves which run up the back and sides of the scalp towards the top. I understand that it is frequently necessary to cut these nerves when taking out the donor strip. I understand that there may be some tingling or other bizarre feelings from time to time as these nerves are healing and growing back. I understand that the nerves could also be irritated by the cautery, which may be necessary to control bleeding. I further understand that it will take 6-18 months for the complete regrowth of these nerves and proper healing, and that sometimes there may be a residual small area of no feeling on the crown or vertex of my scalp.
8. Permission is hereby granted for the taking of pre-operative and post-operative photographs of my procedures for use in medical research, the medical records of my case, and advertising to the general public as long as my identity and face are concealed, so that no one would know who I am. I understand that all information regarding myself and my procedures is always kept privileged.
9. I have no history of keloid formation or ________________________________.
10. I understand that my grafts will take from a few weeks to a few months to begin growing, and I agree to be patient in waiting during that time.
11. I understand that sometimes placing grafts in a given area with some remaining hair in it may cause hair shock, which generally results in the hair in the given area falling out, before regrowing in three to four months, although it may never regrow in rare cases. I also understand that if I have used Rogaine for an extended period, I may be at a greater risk for hair shock and failure to regrow hair, if I discontinue Rogaine.
12. I understand that I may have a few ingrown hairs after my procedures, and I agree that I will immediately come to the office to have the ingrown hairs removed so as not to damage my surrounding grafts.
13. I understand that if I bump my head or otherwise injure the fresh grafts, some of them may come out even though they are held in by crusts. I further understand that if this should happen, I will follow exactly my post-operative instructions regarding this.
14. I understand that if I am of Celtic or Scandinavian genetic background or have very fair skin, or for other reasons, I may heal with very fine white scars around some grafts.
15. I further understand that if I am a slow healer or I am losing hair slowly, it may be necessary to take 1-5 years between transplant procedures.
16. I understand that sometimes a patient may have poor healing, which may cause a ridge where the grafts are (a result of fibrosis during healing). This could result in removal of some or all of the grafts in order to remove the ridging. This ridging condition has never yet been seen with monografts. It also may cause a scar to widen.
17. I understand that occasionally there may be some postoperative oozing or light bleeding at the donor site or from or around a graft. I agree to follow my postoperative instructions and place immediate pressure on such a spot and to subsequently call the doctor.
18. As stated in paragraph 4-c, I understand that I may experience some degree of swelling for 3 to 7 days. It is probably a normal reaction to the local anesthetic.
19. ALLERGIES: I am not known to be allergic to any drug or medication except: ☐ none or (list):

________________________________________________________________

20. I know that the practice of medicine and surgery is not an exact science and, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no absolute guarantee has been made by anyone regarding the operation which I have herein requested and authorized, but that the doctor will make his best effort on my behalf.

21. I agree to carry out the following list of patient responsibilities:

    a) Provide accurate and complete information about present symptoms, past illnesses, and other health matters to the best of my knowledge.

    b) Let the doctor know whether or not I clearly understand what the treatment will be and what is expected of me.

    c) Follow the treatment that the doctor recommends, and the After Hair Transplantation Instructions (post-op instructions) in my Patient Information Book.

    d) Keep appointments and notify the office if I am unable to keep an appointment.

    e) Make prompt payment as agreed.

    f) Be considerate of other patients and medical personnel.

    It is only when patients assume these responsibilities that they are acting as active members of their health care team.

22. I acknowledge that if I have had hair restoration procedures done by another physician, or have had old plug-type grafts done in years past, or require that my donor hair is taken through old scarred donor areas, or I have a limited availability of donor hair, such as in Class 7 hair loss, I can expect somewhat limited results. For example, my density will not be as good as if I had an ample supply of donor hair. Donor scars through old scarred up donor areas will be wider than normal, and several of my grafts that are transplanted into old scarred up receptor areas may not grow.

23. I certify that I have read and fully understand the above consent to operate, and that the explanations therein referred to were made.

24. I have reviewed the Patient Information Book and understand it.

25. I understand that the number of transplant grafts given to me were the best estimates of the doctors. I also understand that I may require addition procedures due to subsequent hair loss, which cannot be predicted, or other factors. I agree to pay the fee below for the number of transplant grafts that I elect to have.

26. I understand that the laws of California will apply.

27. ☐ Previous hair restoration procedures by other physician have resulted in problems which may impede your final results. Generally, our plan is as follows:
    ☐ Your donor hair is limited relative to the size of the balding area. Because of this, our plan is as follows:
    ☐ You are a good candidate for these procedures, our plan is as follows:

    TREATMENT PLAN + FEES ____________________________________________

    ____________________________________________

    ____________________________________________

    THE CURRENT FEES WILL BE HONORED FOR 12 MONTHS FROM THE DATE BELOW.

I have read, understand, and agree with the provisions of paragraphs 1-27 as stated above.

Name (print): ____________________________________________

Signature: ____________________________________________ Date: ______________________________

I certify on this above date I have observed the above-referenced patient reading and signing this consent form of his own free will, and that he is alert and appears to possess the capacity to read and understand the document.

____________________________________________, M.D.

*Pacific Hair Institute, Inc.*

*A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.*