Semone Rochlin D.O.
COSMETIC & RECONSTRUCTIVE SURGEON
BOARD CERTIFIED GENERAL SURGEON

Patient Mammogram Refusal

I have been informed by Dr. Rochlin and/or her staff that they recommend a pre-operative Screening Mammogram prior to receiving a Breast Augmentation Surgery. **Mammography** is the process of using low-dose amplitude-X-rays to examine the human breast and is used as a diagnostic as well as a screening tool. The goal of mammography is the early detection of breast cancer, typically through detection of characteristic masses and/or micro calcifications. Mammography is believed to reduce mortality (death) from breast cancer. No other imaging technique has been shown to reduce risk, but breast self-examination (BSE) and physician examination are considered essential parts of regular breast care.

I understand that without this mammogram that the detection of a preexisting mass or lesion in the breast tissue will not be identified and this mass or lesion can be cancerous which could lead to further surgery such as a lumpectomy, mastectomy, lymph node dissection and could even lead death if not excised. All of my questions and concerns relating to this issue have been discussed and answered to my satisfaction

I **confirm with my signature below that:** the physician has discussed the above information with me, that I have had the chance to ask questions, that all my questions have been answered to my satisfaction, and that I thereby give informed consent. I voluntarily request treatment with by the physician, which has been explained to me, and my questions regarding such treatment, its alternatives, its complications and risk have been answered by the doctor, staff, and/or written information. My questions have been fully and completely answered for me and I have read this document and understand its contents. I hereby give my unrestricted informed consent for the procedure. In the event a dispute arises over the outcome of my procedure, I consent solely to arbitration as a legal means of settlement

Patient Name: (Please Print) _____Date_____

Patient Signature: _____Date_____

Witness Signature: _____Date: _____

Physician Only: I confirm with my signature that I have made time available to discuss with the above-named patient the risks, potential complications, and intended benefits of surgery The patient has had the opportunity to ask any questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested to perform surgery on him/her.

Physician signature: _____Date_____

Our patients are offered a copy of any form they sign