Ismail Ozcan MD
Board Certified Family Physician
122 Portion Rd. Lake Ronkonkoma, NY 11779 Ph: (631) 588 66 65

INFORMED CONSENT FOR HAIR TRANSPLANTATION SURGERY
Follicular Unit Excision (FUE) Donor Harvesting Method

Patient Name: Date of Procedure:

Date of Birth:

I, _____, hereby grant permission for Ismail Ozcan MD, and his assistants/collegues, to perform a Follicular Unit Hair Transplantation procedure (hair transplantation) that includes harvesting the hair via Follicular Unit excision (FUE), the administration of anesthetics and sedatives, by oral or intramuscular routes, as may be necessary or desirable to do this procedure for the treatment of hair loss. FUE may be performed manually and/or by motorized instruments. I understand that my condition has been explained to me as male or female pattern baldness.

I understand that the ability to harvest grafts through FUE is patient dependent and may vary in different parts of a patient's scalp, face, or body. If, in the doctor's judgment, the yield from extraction is, or becomes, too low during the procedure, the doctor may decide not to proceed with FUE.

The FUE procedure has been thoroughly explained to me by the physician, and I fully understand the nature and consequences of the procedure. Dr. Ozcan has explained to me that the donor area may need to be shaved in order to extract the follicular units.

I understand that the procedure of hair transplantation is cosmetic in nature and that I have the option of doing nothing at all, wearing a hairpiece, using medications to treat the hair loss and surgical options such as hair transplants. I understand that there are different ways to perform hair transplants and various harvesting methods including strip harvesting and follicular unit excision, both manually and motorized. These options have been discussed with me and have also been explained in the numerous informational materials made available to me by Dr. Ozcan.

I fully understand that this procedure has limited application. I am aware that the practice of medicine is not an exact science, and I acknowledge there are no guarantees as to the outcome of the surgery/procedure and/or need for additional medical and/or surgical treatment. I understand that there are risks involved in any surgical procedure or treatment and that it is not possible to guarantee or to give assurance of a successful result or to assure an outcome that will meet my goals. This document describes the most common risks associated with hair transplantation surgery. Other risks, though rare, may exist. I recognize that I have been given every opportunity to ask questions and I have made the decision to go forward with the surgery. I clearly understand and agree to the planned surgical procedure. I have been told that hair transplantation is a generally safe procedure; however, I realize that the following are possible events or complications that may occur.

Dr. Ozcan has discussed in detail with me the information that is summarized below:

A. Nature and purpose of Hair Transplantation

Hair transplantation is a procedure which utilizes donor hair in bald areas of the scalp to minimize male pattern baldness.

In hair transplantation surgery, grafts of skin which have hair roots (follicles) are taken from the donor areas (commonly scalp, beard, and body hair). These grafts are then placed in the bald area. Patients can usually return to work in 1 to 4 days, but this can vary depending upon the area of the transplant, and the amount that was transplanted.

The grafts will scab over and these scabs will fall off in about 7 to 14 days. The hair shaft in the grafts will temporarily fall out about 2 to 3 weeks after surgery (the follicle stays alive in the scalp). The hair will begin to

regrow beginning about 3 – 4 months after surgery.

Unless informed otherwise, you will be undergoing "follicular-unit" hair restoration. You agree that you understand and accept the following by writing your initials at each of the following statements:

_____ Follicular-units are microscopically dissected grafts that contain 1 - 4 hairs each.

_____ The percentage of 1, 2, 3 and 4 hair grafts vary from person to person.

_____ The primary purpose of using follicular-unit grafts is to obtain a natural look (a non-pluggy look).

_____ Density is related to the number of grafts placed in a given area. Density will decrease as a fixed number of grafts are spread over a larger area.

_____ It is commonly recognized that one needs approximately 50% of their original density to have the appearance of high density hair. A 50% density requires approximately 50 grafts per square centimeter. Grafting beyond 50% is unrealistic for most patients with advanced balding patterns since it could compromise density in the donor region.

_____ Other factors contribute to the appearance of density: fine hair, low follicular-unit hair counts and a dark hair color/light skin color combination can increase the 50% density requirement needed for producing cosmetically acceptable density.

_____ There are limits to the density that hair can be planted in a single surgery, as increasing the graft density within a zone of thinning hair increases the risk of "shock-loss" to the thinning hair.

_____ Unless dense-packing is performed (approximately 50 grafts per square centimeter or more), multiple sessions will be required to achieve the appearance of high density. Session number requirements for high density hair vary depending on the grafting density performed during any given procedure.

_____ Cosmetically acceptable density varies from person to person. Your long-term density potential is based on graft availability from your donor region. Donor hair supply typically diminishes with time, especially if the balding process has not stabilized.

_____ When more than one surgery has been recommended at consultation, it is common and expected that a patient may perceive the density of the first surgery as being thin hair rather than thick hair. As stated above, more than one surgery is often needed in order to meet density (thickness) expectation.

B. Risks

_____ I understand that among the known risks are bruising, infection, discomfort at the donor and or recipient site(s), numbness, redness (the degree of redness varies between individuals) infection, swelling, allergy to suture material, foreign body reaction, bleeding, swelling, temporary or permanent hair loss, shock loss and or no growth of transplanted hairs.

_____ I understand that FUE carries additional risks over strip harvesting such as increased risks of transection of follicular units during the extraction process, increased overall scarring in the donor area, poorer growth, and the ability to extract less grafts per surgical session.

_____ SCARRING: Every time an incision is made in the human body, a scar will occur, and the final appearance of the

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scar can vary between individuals. Every effort will be made to make any scarring as inconspicuous as possible. Thickened or raised scars (hypertrophic/keloids). Significant scarring is more likely to occur in people who have had a history of excessive scarring or who have had previous transplants taken from the donor area. I have informed Dr. Ozcan if I have a history of keloid formation.

_____ SEDATIVES: You may be given sedatives during your procedure to relax you and make you more comfortable. The sedatives may include Valium or Xanax given orally and Versed administered intra-muscularly. These medications can depress respiration in some patients. Your oxygen levels will be monitored during the procedure. If you are sensitive to these medications or have any respiratory problems, please let the doctor know.

_____ ALLERGIC REACTIONS: I understand that there may be unusual, unexpected or allergic responses to drugs, medications, suture materials, or foods, prescribed or used during the surgical procedure. I recognize that it is important for the physician to be informed of any problem I, or any member of my family, have had with reactions to drugs and also the medications | have taken in the past six months, including over-the-counter drugs, especially aspirin and any street drugs.

I am allergic to _____
_____ I am not allergic to any drugs, medications, suture materials, or foods _____.

_____ STEROIDS: As discussed, oral corticosteroids (prednisone) will be used to minimize swelling after the hair transplant. I understand the slightly increased risk of this treatment, including the rare complication of degeneration (aseptic necrosis) of the hip joint. I understand the nature of the cortisone treatment and agree to this preventative treatment.

_____ FOLLICULITIS: Folliculitis is an uncommon problem in which hair follicles become infected with bacteria. Folliculitis usually appears in the postoperative period. The associated symptoms include redness around the grafts, pustules around emerging hairs, and itching. There may be some associated loss of hair in the involved follicles, but since the problem is localized to individual hair follicles, the loss is rarely significant from a cosmetic standpoint. The treatment consists of oral antibiotics that may be given for an extended period of time.

_____HAIR LOSS: There may be temporary hair loss in the back of the scalp in the area of the harvested hair. This hair will generally grow back. In the transplanted area, you may experience shedding of your existing hair following the surgery (a process called telogen effluvium). If this hair is at or near the end of its normal life span (miniaturized hair), it may not return. Because genetic balding is a continuous process, you may continue to lose more hair over time. If this occurs, a subsequent hair transplant procedure may be desired.

_____ HAIR TEXTURE CHANGES: When your new hair begins to grow it may be more kinked or wavier than your original hair. Over time the hair generally resumes its normal character. It is possible that these hair texture changes may persist.

_____ FAILURE OF TRANSPLANTED HAIR TO GROW: As in all surgical procedures results cannot be guaranteed. It is possible that some or all of the transplanted hair may fail to grow. Every effort will be made to give you the maximum yield from your transplanted hair. I acknowledge there are no guarantees as to the outcome of the surgery/procedure and/or need for additional medical and/or surgical treatment.

_____ NUMBNESS AND PAIN: Numbness of the scalp/face may occur due to necessary cutting of fine nerve fibers in the skin. This is expected to gradually disappear over several months, but it is possible that all of the sensations may not return. Rarely nerve injury may occur, resulting in long term or possibly permanent numbness and/or pain in the scalp.

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_____ SMOKING: Smoking causes constriction of blood vessels and decreased blood flow to the scalp, predominantly due to its nicotine content. The carbon monoxide in smoke decreases the oxygen carrying capacity of the blood. These factors may contribute to poor wound healing after a hair transplant and can increase the chance of a wound infection and scarring. Smoking may also contribute to poor hair growth. The deleterious effects of smoking wear off slowly when one abstains, particularly in chronic smokers, so that smoking puts one at risk to poor healing even after smoking is stopped for weeks or even months. Although it is not known exactly how long one should avoid smoking before and after a hair transplant a common recommendation is to abstain from 1 week prior to surgery to 2 weeks after the procedure.

_____ SUN DAMAGED SKIN: After your transplant, you must still protect your scalp from the damaging rays of the sun. Your new hair makes close observation of your scalp important because unusual new skin growths, or skin changes, may be more difficult to see. In addition, if you have a history of skin cancer or sun damaged skin, you should be followed by your dermatologist. It is possible that significantly sun damaged skin may hinder hair growth.

_____ INFECTION: The symptoms of infection include swelling, redness, tenderness or pus at the surgical site and may be associated with fever or chills. If you experience any of these symptoms, contact us at once.

_____ OTHER: There may be temporary swelling, discoloration, or bruising associated with the procedure. There may be the formation of a cyst at a graft site, ingrown or buried hairs, hematoma (localized blood clot), or rejection of a graft. In areas of scar tissue, grafts may grow poorly or not at all.

_____ I am aware that, in addition to the risks specifically described above, that there are other risks such as loss of blood and infection that may accompany any surgical procedure, as well as injury to nerves which may lead to partial numbness. I realize that common to any procedure is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I also realize that the following risks and hazards may occur in connection with this particular procedure:

_____ Unsatisfactory appearance/ unmet expectations

_____ Creation of additional problems such as poor healing, skin loss, or painful or unattractive scarring.

_____ Blood collection under skin (hematoma) requiring removal

_____ I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth above, including terminating the procedure at any point. I therefore further authorize the above named doctor or his designated assistants to perform procedures as are in his professional judgment necessary and desirable.

C. For patients who have had prior hair restoration surgery at another institution:

_____ I acknowledge that prior to contacting Ismail Ozcan, MD, I received Hair Transplants/Scalp Reductions from another physician and the results of these procedures may have been below my expectations. I further acknowledge that Ismail Ozcan, MD, PC, and employees, bear no responsibility for my present condition. I also acknowledge that I have been informed that Ismail Ozcan, MD, PC physicians may not be able to correct my condition, although they will attempt to do so. 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 recipient areas may not grow.

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D. Anesthesia

_____ ANESTHESIA REACTIONS: Local anesthetics (lidocaine, bupivacaine) with Adrenaline (epinephrine) may have effects on many of the body's organ systems, including the heart. Such effects may include allergic reactions, irregular heartbeats, or even, in unusual circumstances, a heart attack. Such risks are uncommon with surgical procedures performed under local anesthesia. Patients on the type of heart or blood pressure medications called **"beta-blockers"** may be particularly sensitive to epinephrine. Some patients may experience a temporary light-headed episode as a nervous reaction to injections. This reaction may cause a drop in blood pressure and lead to fainting. This condition is easily and relatively rapidly treated. If you are on any heart or blood pressure medication please list below.

I am currently taking _____
_____ I am not on any heart or blood pressure medication _____

E. Alternatives to Hair Transplantation Surgery

_____ Alternative methods do exist in eliminating or masking baldness (i.e. hair flaps, prosthetic devices, or drug therapy). I am fully aware of these alternatives and have chosen hair transplantation as the best solution.

F. Sedatives

_____ You may be given sedatives which will be managed by the physician during your procedure to relax you and make you more comfortable. The sedatives may include Valium or Halcion given orally and Versed administered intra-muscularly. These medications can depress respiration in some patients. Your oxygen levels will be monitored during the procedure. If you are sensitive to these medications or have any respiratory problems, please let the doctor know.

G. Driving Caution

_____ I am aware that I will be given medications during and after the surgical procedure that may cause drowsiness and/or impair my judgment. I understand that I will not operate a motor vehicle, or dangerous machinery, or make any important decisions the day of surgery or at any time while I am under the influence of these medications.

H. Informed Consent

_____ I have had sufficient opportunity to discuss my condition and proposed surgery with Dr. Ozcan and all my questions have been answered to my satisfaction. The procedure, its indications, risks and alternatives have been explained to me by my physician, and through the inquiry package, and the preoperative instructions. I recognize that during surgery unforeseen conditions can occur that may alter the course of surgery and necessitate deviating from the original plan. This may include the transplantation of more or fewer grafts than scheduled. I hereby authorize and request the surgeon to use his/her professional judgment to complete the surgery in a manner that will produce the best results in the safest way possible. I have read and understand this consent for surgery. I have been given the opportunity, by my physician, to ask questions, and all of my questions have been answered to my full satisfaction. Any objections have been noted or stricken and initialed by me.

_____ This consent was read and signed by me while I was not under the influence of medications or other substances that can cause drowsiness or impair judgment.

_____ I understand that Ismail Ozcan, MD, does NOT adhere to advance directives (living wills).

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_____ I believe that I have adequate knowledge on which to base an informed consent to the proposed treatment.

_____ 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 for 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 8-18 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, hair line, 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 previous 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 average treatment plan is 1-3 session in each area depending on the density desired.

I. Surgically Removed Tissue

_____ Any tissue surgically removed will be disposed of in accordance with customary practice.

J. Patient Responsibility

_____ I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by facility personnel not to drive until all effects of medication have worn off. I understand this to mean that I should not drive until the day after my surgery/procedure or as directed by my physician.

_____ I understand that I am to leave valuables at home and acknowledge that I have been advised by facility personnel to do so. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.

_____ I understand that if I am pregnant or if there is any possibility that I may be pregnant, I must inform the facility immediately since the scheduled operation/procedure could cause harm to my child of myself.

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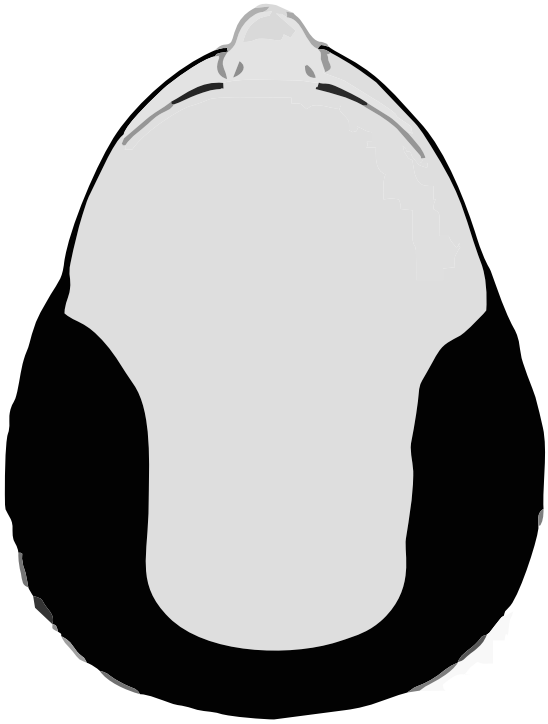
K. Hair Transplant Planning and Incision Confirmation (will be filled out by Dr. Ozcan the day of surgery)

_____ I approve of the hairline design and proposed follicular unit graft placement areas that were created by Ismail Ozcan, MD, FACS and I, as roughly diagramed above. I was involved in the design of the hairline and designating the areas to be transplanted. I have been given the opportunity to make any final adjustments. Preoperative photographs were taken to document the design.



L. Cooperation

_____ I agree to keep Dr. Ozcan and his staff informed of any change in my permanent address, and I agree to cooperate with them in my post-operative care. I hereby authorize Dr. Ozcan aided by such assistants, photographers, or technicians as he may engage for this purpose, to take full face and scalp photographs and/or videotapes of me as he may desire before, during, and after the operation which is to be performed on me for medical records purposes. I relinquish all right, title, and interest in these photographs/videotapes to Dr. Ozcan. I should understand that photographic documentation for medical purposes is the purpose of the photographs.

_____ I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give an informed consent.

_____ In the event of any accidental exposure of any blood or bodily fluid to a physician, contractor, or employee of the facility, I consent to testing for HIV and Hepatitis.

_____ I understand that in the rare event that hospitalization is required during or immediately after the surgery, my physician will arrange for my transfer to a local hospital.

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PLEASE READ ALL THE PARAGRAPH FORTH ABOVE. WE WILL HAVE YOU SIGN BELOW ON THE DAY OF SURGERY:

PATIENT: _____ PRINT: _____

DATE: _____ TIME: _____

I certify that on this date I have observed this patient carefully read and sign this consent form of his/her own free will.

WITNESS: _____ PRINT: _____

DATE: _____ TIME: _____

I certify on this date I have reviewed this consent form with the patient, that I have informed the patient and his/her representative of the nature of this operation/procedure, alternatives methods of treatment, including non-treatment, and the risks and expected outcomes associated with this procedure, and that he/she is alert and appears to possess that capacity to read and understand the document.

PHYSICIAN: _____ PRINT: Ismail Ozcan, MD, FACS

DATE: _____ TIME: _____