Gulf Coast
HAIR RESTORATION

Woessner Medical Clinic
750 Camp Street, New Orleans, LA 70130
Phone (504) 525-5262 Fax (504) 524-4671

Dr. William Woessner has agreed to perform Hair Transplant Surgery upon me under local anesthesia with oral Valium sedation. Dr. Woessner has in no way guaranteed any results. He will, of course, use all of the knowledge and experience of his 30 years of medical practice to bring about the best result possible and believes that patients will achieve a satisfactory result. He agrees to replace at no charge any grafts that do not grow to maturity, providing the patient has adequate donor hair available within one year of the surgery date. I agree that Dr. Woessner will be the sole judge in such matters as to whether grow to maturity, etc.

I am aware that surgery does not slow down or stop the aging process, nor the thinning and loss of hair that may normally accompany the aging process.

I am aware that complications from anesthesia, surgery and unforeseen events are possible with such surgical procedures. Such complications might include bleeding, scalp hematoma, infection, failure of the donor site to heal in a timely fashion, popping-out of grafts, hypertrophic scarring, cyst formation, poor growth of grafted hair, post surgical hair loss, hypo or hyper pigmentation, nerve damage, drug toxicity or allergy, syncope (fainting), seizures and cardiopulmonary arrest.

I am aware that surgical incisions may heal with visible scars in spite of the best efforts to minimize scarring. I am aware that I may need future medical treatment and/or hair restoration surgery to obtain the density that I desire.

I have had ample explanation regarding this procedure and my questions have been answered to my satisfaction. I agree to return to this clinic in six months and twelve months post-operatively, and may receive a copy of my before and after pictures after the twelve month visit.

I am aware that there are other modalities to deal with hair loss and choose this one after careful consideration.

I request and consent to an FUE or FUT of hair from my side and posterior scalp onto my _____ scalp, knowing full well that there could be complications and unforeseen results.

FUE: # of extractions: _____ Size of extraction tip _____

FUT: Length of Donor Strip: _____ Width of Donor Strip: _____

Approximately Equivalent to #: _____

Patient's Signature: _____Date _____

Witness: _____Date _____

Physician Signature: _____ Date_____