

PRE-TREATMENT INSTRUCTIONS: AUTOLOGOUS FAT INJECTION

Patient Name _____ Date _____

Surgical Facility _____ Procedure Date _____

Arrival Time _____

A successful treatment requires a partnership between you and _____, MD

The following instructions are essential to a safe experience and good outcome. Use this as a checklist as you approach your treatment date. If you are unable to comply with these instructions, you must notify our office as soon as possible.

As a result, your treatment may have to be postponed or delayed, at the judgment of _____, MD

This is essential to your health and safety.

TWO TO THREE WEEKS OR MORE BEFORE YOUR PROCEDURE

There may be several weeks between your decision to undergo autologous fat injections and your actual surgical date. During this time there are several important considerations:

Practice proper skincare. Practicing good skincare is an important factor in your overall appearance and the quality of your skin. This includes gentle cleansing morning and evening, proper moisture and daily use of a broad spectrum sunscreen, whether you are expecting outdoor sun exposure, or just the incidental exposure of daily life. Proper skincare is also important to help you maintain your results. Special recommendations for your skincare include:

- _____
- _____
- _____
- _____

Good nutrition: Eat well during the weeks prior to your procedure. Crash dieting, over-eating or high alcohol intake can greatly affect your overall health and well-being. A healthy, balanced diet is essential. Also, begin taking the following supplements daily:

- _____
- _____
- _____
- _____

Stop smoking: Smoking can greatly impair your ability to heal. You must be nicotine and smoke-free for at least 4 weeks prior to your procedure. You must also be free of any nicotine patch or nicotine-based products for a minimum of 4 weeks prior to your procedure.

Lead a healthy lifestyle. In the weeks prior to your procedure, maintain the best of health and hygiene. A lingering cold, virus, or other illness can result in your procedure being rescheduled. Make certain to address any illness immediately, and advise our office of any serious illness or change in your health.

Prepare and plan: Schedule any time off of work, and any support you will need at home in the days following your procedure, including housework, childcare, shopping, and driving. If you will undergo any form of sedation, make certain a responsible adult is confirmed to drive you to and from your appointment, and that someone is confirmed available to stay with you around the clock for 24 hours, at least, following the procedure.

Pre-treatment: Make certain to schedule all of the pre-procedure treatments as prescribed:

Botulinum Glabella Crow's Feet Other _____ None prescribed
 _____ _____

Pre-treatment testing: Make certain to schedule all of the pre-treatment testing and clearance you have been given. Refer to the **Pre-surgical Lab and Testing Orders** form. Make certain all test results are received by Dr. _____ as required. If medical clearance is required and not yet received, your procedure may be cancelled at **your cost**.

Fill your prescriptions: Some pain medication prescriptions may need to be filled **ON THE DAY** these prescriptions are written. Our office will advise you accordingly. Your prescriptions include:

Antibiotic:	_____	_____ mg	_____ x per day
Pain medication:	_____	_____ mg	_____ x per day
Other:	_____	_____	_____
Other:	_____	_____	_____
Supplements:	_____	_____	_____

STOP taking the following no less than two weeks before your procedure. Taking any of the following can increase your risk of bleeding and other complications:

- | | |
|---|--|
| <input type="checkbox"/> Aspirin and medications containing aspirin | <input type="checkbox"/> Garlic Supplements |
| <input type="checkbox"/> Ibuprofen and anti-inflammatory agents | <input type="checkbox"/> Green Tea or green tea extracts |
| <input type="checkbox"/> Vitamin E | <input type="checkbox"/> Estrogen supplements |
| <input type="checkbox"/> St. John's Wort | <input type="checkbox"/> All other medications indicated |
| <input type="checkbox"/> Gingko | |

Vital information: A pre-treatment visit or call may be required to review your health, your goals, and any vital information including allergies and health considerations.

Your pre-treatment (visit)(call) is scheduled for: _____

ONE WEEK BEFORE PROCEDURE

Confirm your day of procedure plans. This includes your transportation and after-care (a responsible adult for the first 24 hours, around the clock if you have had any sedation or general anesthesia).

Review your prescription orders and instructions.

Confirm all lab results and paperwork have been received by Dr. _____ if you have not already done so.

Shop for necessary post procedure items: These may include:

- | | |
|---|---|
| <input type="checkbox"/> Soft white washcloths or gauze squares | <input type="checkbox"/> Ointment _____ |
| <input type="checkbox"/> Sipping cups | <input type="checkbox"/> Concealing make-up _____ |

Continue to practice healthy habits, skincare and fitness. No strenuous exercise. No saunas, hot tubs, steam baths, or skincare treatments other than those prescribed. **No smoking or alcohol.**

Find your comfort zone. Locate the most comfortable place where you can gently recline and recover. You don't want to be testing locations or pillows immediately following your procedure. Shop for magazines, books and other things to keep you busy and entertained for a day or two.

ONE DAY BEFORE THE PROCEDURE

_____ **Pack your bag for the day of your procedure.** This should include:

- | | |
|---|---|
| <input type="checkbox"/> All paperwork | <input type="checkbox"/> Large-framed dark tinted sunglasses |
| <input type="checkbox"/> Your identification | <input type="checkbox"/> A wide brimmed hat or light scarf |
| <input type="checkbox"/> All prescription medications | <input type="checkbox"/> Saltines or other crackers in case of nausea during your ride home if you have received sedation |
| <input type="checkbox"/> Warm, clean cotton socks | |

_____ **Shower as directed.** Use an anti-bacterial, fragrance-free soap. Shampoo your hair. Do not use any hair gel or other styling products, scented skin creams or moisturizers. Do not use any deodorant, hair spray, perfume, or cosmetics. Remove all finger nail and toe nail polish.

IF YOU WILL UNDERGO INTRAVENOUS SEDATION OR GENERAL ANESTHESIA

_____ **Expect a pre-anesthesia call to review your state of health and anesthesia.**

_____ **Confirm your route to and from your appointment, with the responsible adult who will drive you.** Also confirm plans with your 24-hour support person and make certain he or she has all of your post-operative instructions.

_____ **Do not eat or drink anything after 12 midnight.** No candy, gum, or mints. Anything more than a small amount of water as needed for brushing teeth or swallowing medication may result in the need to cancel the procedure.

THE DAY OF THE PROCEDURE

_____ **Dress appropriately.**

- **Do not wear cosmetics, jewelry of any kind, contact lenses, hair clips, or body piercings.** (If there is something you cannot remove, let the admitting nurse know right away.)
- **Wear comfortable, clean, loose-fitting clothing.** Wear only a top that zips or buttons up the front. Do not wear pullovers, turtlenecks, or any tight-fitting top or bottom. You may wear a robe. Wear slip-on shoes. Wear clean cotton socks, as the operating room can feel cool.

IF YOU WILL UNDERGO INTRAVENOUS SEDATION OR GENERAL ANESTHESIA

_____ **NOTHING by mouth.** Anything more than a small amount of water as needed for brushing teeth or swallowing medication may result in the need to cancel the procedure. This includes candy, gum, and mints.

I have read and understand all of the above instructions. I understand that following these instructions is solely my responsibility. I understand that it is also my responsibility to ask my doctor and his or her staff any questions I have related to these instructions or about my procedure, health and healing.

Patient Signature

Date

Printed Name of Patient

Signature of Practice Representative and Witness