

PRE-TREATMENT INSTRUCTIONS: NON-ABLATIVE PEELS AND RESURFACING TREATMENTS

Patient Name _____

Date _____

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 for your treatment. If you are unable to comply with these instructions, you must notify our office as soon as possible. As a result, your treatment may be postponed, delayed or discontinued at the judgment of _____, MD. This is essential to your health and safety.

PRIOR TO YOUR TREATMENT

Treatment may begin on the day it is prescribed, or there may be several weeks between your decision to undergo treatment or when your treatment will begin. During this time there are several important considerations:

Practice proper skincare. Your treatment may have to be postponed if your skin is sunburned, has any open wounds or active open cold sores.

NO SUN EXPOSURE for a minimum of 2 weeks prior to your treatment. Your procedure may have to be postponed if you have any tan at all. This includes self-tanners, tanning beds, spray on tans or any other treatment that can change the color of your skin. Also, avoid beta carotene supplements which can alter the pigment in your skin. Resurfacing cannot be performed on skin that has had recent sun exposure, or is tan. Avoid any direct sun exposure to the area that will be treated and wear a SPF 30 daily even if the region to be treated is covered by clothing. The need to post-pone your procedure may ***be at your cost.***

The following must be stopped or avoided for at least 7 days prior to your treatment: electrolysis, waxing, laser hair removal, masks, other peels or laser/light based treatments, hair dyeing, permanent wave or straightening, depilatories, retinoids (Retin-A, Renova, Avage, etc.), exfoliation by loofah, sponges, scrubs or microdermabrasion.

Fill your prescriptions and take/apply them according to the instructions you are given. Our office will advise you accordingly. Your prescriptions include:

_____	_____ mg	_____ x per day
Topical	_____ mg	_____ x per day
Topical	_____ mg	_____ x per day
Other	_____	_____
Supplements	_____	_____
_____	_____	_____

THE DAY OF YOUR TREATMENT

- **If you have preferred skincare and sunscreen products, bring these with you to apply after treatment.**
- **Avoid shaving treatment areas on the day of treatment.**
- **Do not apply moisturizers, creams or fragrances prior to your treatment.**
- **Wear comfortable, clean, loose-fitting, non-irritating clothing in the area to be treated.** If treatment is planned for the face, wear a wide-brimmed hat to shade your face as you leave the office.

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