PRE-TREATMENT INSTRUCTIONS: SOFT TISSUE FILLER INJECTIONS

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

PRIOR TO YOUR INJECTION TREATMENT:
Treatment may occur on the day it is prescribed, or there may be several days or weeks before your treatment is scheduled. In general, the following is recommended prior to soft tissue filler injections.

_____ **STOP taking or using the following no less than 2 weeks before your treatment.** This may reduce any bruising that may occur.

- ☐ Aspirin and medications containing aspirin
- ☐ Ibuprofen and anti-inflammatory agents
- ☐ Vitamin E
- ☐ St. John's Wort
- ☐ Garlic Supplements
- ☐ Green Tea or green tea extracts
- ☐ Gingko
- ☐ All other medications indicated

Allergy pre-testing may be required. The use of certain fillers, namely those that include bovine collagen, requires allergy pre-testing that must occur a minimum of 2 weeks prior to treatment. Allergy testing does not, however, eliminate the potential of an allergic reaction.

THE DAY OF TREATMENT
If you request, or if Dr. (NAME) recommends, you may be given a topical anesthetic cream to apply prior to arriving at our office. Follow instructions for applying the anesthetic creams exactly as directed. Icing is an alternative that may be recommended.

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