

PRE-SURGERY INSTRUCTIONS: CORONAL BROWLIFT

Patient Name _____

Date _____

Surgical Facility _____

Surgery Date _____

Arrival Time _____

A successful surgery requires a partnership between you and Dr. Huai C. Pan and his staff

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 Dr. Pan. This is essential to your health and safety.

THREE WEEKS OR MORE BEFORE SURGERY

There may be several weeks between your decision to have surgery 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 surgery. Crash dieting, over-eating or high alcohol intake can greatly affect your overall health and well-being. A healthy, balanced diet is essential.

- _____ _____
- _____ _____

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

Lead a healthy lifestyle. In the weeks prior to surgery maintain the best of health and hygiene. A lingering cold, virus or other illness can result in your surgery 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 surgery, including housework, childcare, shopping and driving. Make certain a responsible adult is enlisted and confirmed to drive you to and from surgery, and that one is confirmed available to stay with you around the clock for 24 hours, at least, following surgery.

_____ **Pre-operative treatment.** Make certain to schedule all of the pre-operative treatments as prescribed:

Botulinum Glabella Crow's Feet Other _____
 _____ _____

_____ **Pre-operative testing.** Make certain to schedule all of the pre-operative 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 our office as required

_____ **Relax and enjoy life.** Stress and anxiety over life's daily events, and even your planned surgery can affect you. While some anxiety is common, any serious stress, or distress over the thought of surgery is something you must discuss with our office. We are here to support you and answer all of your questions. We want your decision to be one made with confidence.

TWO to THREE WEEKS BEFORE RESURFACING

This is an important planning and preparation time. Follow all of the skincare and health habits you have begun in addition to the following:

_____ **Prepare and plan:** Put your schedule together for the day before, day of and first few days following the procedure. Share this with all of your key support people.

_____ **Schedule your hair care:** You may not color or perm your hair in the 4-6 weeks following surgery. So be certain to schedule these services now.

_____ **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: _____
Pain medication: _____
Muscle Relaxant _____
Other: _____
Supplements: _____

_____ **STOP taking the following for the duration before your surgery. 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 |

_____ **Pre-operative clearance and information:** Make certain to undergo *ALL* pre-operative testing. Refer to the *Pre-surgical Lab and Testing Orders* form. Make certain all test results are received by our office as required. If medical clearance is required and not yet received, surgery may be cancelled at *your cost*.

_____ **Vital information:** A pre-operative visit is essential to review your health, your goals, and any vital information including allergies and health considerations.

Your pre-operative (visit) is scheduled for: _____

THE DAY OF SURGERY

_____ **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 surgery. This includes candy, gum, mints.

_____ **Dress appropriately.**

- **Do not wear cosmetics, jewelry of any kind, contact lenses, hair clips, body piercing:** (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. Wear slip on shoes. Wear clean cotton socks, as the operating room can feel cool.

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 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