Texas Facial Plastic Surgery and ENT
555 East Basse Rd, Ste 201
San Antonio, TX 78209
Office: 210-468-5426; Fax: 210-468-3282

Consent

_____I understand that the purpose of this procedure (Active FX, Deep FX, Total FX, MaxFX, with / without dermal fillers) is for ________________________. There are several alternatives to treatment including but not limited to other laser treatments, chemical peels, facial rejuvenation or no treatment at all.

_____I understand that the possible risks of the procedure include crusting, pain, purpura, swelling, redness, brusing, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation, and unforeseen complications. Eye injury is possible but unlikely. Eye protection measures will be properly used throughout laser treatment sessions.

_____I understand that a single procedure will most likely fail to completely remove all my dyschromia, or textural problems in the area treated. Individual response will vary according to skin types, hair color, degree of tanning, follow-up care, and the body area being treated.

_____I understand that treatement may be painful, but this is typically manageable without any pain relief medication. I agree to receive local analgesic, sedatives,and amnestic medications before, during, and after the procedure for patient comfort and pain control. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopgimentation (skin lightening), may occur in treated skin. This may take several months to resolve, it at all. Unprotected sun exposure in the weeks following treatment is contraindicated as it may worsen this condition. Blistering of the skin may occur. Scarring can occur but is uncommon.

_____I further agree that any pictures or video taken of me may be used for either teaching, publication, or advertising, if considered appropriate, unless I notify the doctor in writing that he or she is not to use these photographs prior to publication.

_____I have been asked at this time whether I have any questions about this procedure and do not. I understand the procedure and risks, accept the risks, and request that this procedure be performed on me by the doctor and / or qualified staff.

____ ________________
Name of Patient (please print) Date

____
Signature of Patient

____ ________________
Name of Witness (please print) Date

____
Signature of Witness

____ ________________
Signature of Practitioner Date

Check List for My Surgery

The following is a check list for you to complete.

______ My surgeon is Jose Barrera, MD, FACS.

______ My surgery is scheduled for (date) ____

______ My surgery will take place at (location) ____

______ I have received medical clearance from my primary care physician or specialist, if indicated by my surgeon.

______ My pre-operative appointment in is scheduled for __________________________________

______ My post-operative appointment in is scheduled for _________________________________

______ I understand that the Surgery Coordinator will be contacting my medical insurance company to obtain authorization for my surgical procedure(s). I understand that if authorization is denied, I will be financially responsible for all expensed for the surgical procedures prior to the day of surgery.

______ I will bring my updated Personal Medication Card listing prescription, non-prescription medications and herbal preparations, including name, dosage and concentration with me to my pre-operative appointment with the anesthesiologist and to the hospital on my surgery day.

______ I have received a prescription for pre- and post-procedure medications.

______ I know what medications I should and should not take prior to surgery. I understand that if advised to take any medications I will take them with only a sip of water.

______ I have received a copy of the Pre- and Post Laser treatment information sheet.

______ I will wear loose, comfortable clothing to the procedure visit on the day of surgery.

______ I understand not to wear perfume, makeup, deodorant, nail polish or jewelry on the day of surgery.

______ I will leave my valuables at home (jewelry, laptop computers, cash and credit cards).

______ I have made arrangements for someone to drive me home after I have been discharged.
I understand that I will not be able to drive myself or take a taxi home.

______I have informed my physician of known allergies to medications which include:

____.

Name of Patient (please print) Date

____
Signature of Patient

Pre- and Post Laser Treatment Information Sheet

Procedure Medications

Eye drops

- **Tobramycin Opthalmic Solution** – use 2 drops at night time or four times a day as directed the day after the procedure.

Prophylactic anti-viral

- **Valtrex (Valacyclovir) 500 mg.** Take one capsule twice a day x 7 days. Start one day before the procedure.

Antibiotics

- **Keflex (Cephalexin) 500 mg**. Take one twice a day x 10 days to start one day before the procedure.
- **Doxycycline 100 mg**. Take one tablet twice a day x 10 days to start one day before the procedure.

Miscellaneous

- **Vicodin (Hydrocodone) 5mg/325 mg**. Take one tablet every 4 – 6 hours as needed for severe pain.
- **Celebrex 100 mg**. Take one tablet every 4 – 6 hours as needed for moderate pain.
- **Tylenol 500 mg** . Take one tablet every 4 – 6 hours as needed for mild pain.
- **Valium (diazepam) 10 mg**. Take one tablet the night before the procedure as needed for anxiety. Take one tablet the day of the procedure as directed.

Laser Post Procedure List

- Gentle Cleanser: Obagi   Purpose (OTC)   Cetaphil (OTC)
- Occlusive Ointment: Aquaphor ointment (OTC)   Elta MD Laser balm or kit
- Non-Occlusive Moisturizer: Cerave Lotion (OTC)   Cetaphil (OTC)
- Sun block 30+ SPF: Elta MD   Obagi Healthy skin   Other:
- Lubricating eye drops (any OTC)
- Cool Compressions: Frozen peas or face cool pack
- Mineral Make-up: Glo Minerals
- Steroid cream / ointment (prescription given by the doctor if needed)
- Hat to protect treated area from sun exposure

____   ____________________

Name of Patient (please print)   Date

____

Signature of Patient