

Steven T. Constantine, D.O.

INSTITUTE OF FACIAL & COSMETIC SURGERY
5929 S. FASHION BLVD. (280 EAST)
MURRAY, UT 84107
TELEPHONE: (801)261-3637

SCHEDULING YOUR SURGERY

SCHEDULING YOUR SURGERY IN AN "ON CALL" PROCESS

Please be aware that your surgery time is variable. All surgeries are scheduled for a specific date not a specific time. Patients are on call for their procedure and will be called with a 2 hour on call time frame the evening prior to surgery.

If you are not available for your surgery when the O.R. is prepared for your procedure, additional O.R. charges may apply at the rate of \$250.00/hour. The next patient may be called in to take your slot if you cannot be reached in a reasonable amount of time. This is necessary due to the extremely high cost of the operating room personnel and anesthesia time.

Thank you for your attention to this matter.

I agree to the above terms and conditions regarding the scheduling of my surgical procedure. I also agree to be available on call the entire day of my surgery.

Patient Signature: _____ Date: _____

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SUPPLEMENTS TO DISCONTINUE DURING THE PERI-OPERATIVE PERIOD

2 (TWO) WEEKS PRIOR TO SURGERY

Although many of the nutritional supplements may be beneficial when used appropriately, their use around the time of surgery may increase risks and complications of surgery and anesthesia. Please discontinue use of these products 2 weeks prior to surgery and for 2 weeks after surgery to diminish these risks.

- **Aspirin** *(Excedrin and arthritis pain formula – all varieties contain aspirin in them)
- **Advil / Motrin / Ibuprofen**
- **Aleve / Naprosyn / Naproxen**
- **Bilberry** (vaccinium myrtillus) – has anti platelet activity, will increase bleeding and bruising.
- **Cayenne** (capsicum annuum) – temperature regulation may deteriorate.
- **Dong Quai** (angelica sinensis) – may increase bruising and bleeding.
- **Echinacea** (Echinacea augustifolia) _ decreases effectiveness of liver enzyme used to degrade anesthetics. Can prolong arousal from anesthesia.
- **Feverfew** (tanacetum parthenium) – may increase bleeding and bruising
- **Fish Oil** – may increase bleeding.
- **Garlic** (allim sativum) – may increase bleeding and bruising.
- **Ginger** (zingiber officinate) – may increase bleeding and bruising.
- **Ginkgo Biloba** (ginkgo Biloba) – one of the strongest anticoagulants, will increase bleeding and bruising.
- **Ginseng** (panax ginseng/panax quinquefolium) – may increase bleeding and bruising.
- **Hawthorne** (cratagus laevitata)- interacts with heart medications.
- **Kava Kava** (piper methysticum)- may delay arousal from anesthetics.
- **Licorice Root** (clicyrrhiza glabra) –may increase blood pressure and electrolyte disturbances.
- **Ma Huang** (ephedra sinica) – increases arrhythmias, high blood pressure and death.
- **Melatonin** - may delay arousal from anesthetics.
- **Red Clover** (trifolium pretense) - may increase bleeding and bruising.
- **St. John's Wort** (hypericum perforatum) – multiple adverse drug interactions.
- **Valerian** (valeriana officinalis) – decreases effectiveness of anesthetics and pain medications.
- **Vitamin E** - may increase bleeding and bruising.
- **Yohimbe** (corynanthe yohimbe) – may prolong arousal from anesthesia

Please ask your physician prior to beginning supplementation after surgery. Each patient may heal differently and treatment should be individualized in the post-operative period.

Thank you for your attention to this very important matter. Each of us has the mutual goal of the best surgical outcome, and with your attention and compliance with the suggested treatment you may increase the odds of an exceptional recovery and final result.

Patient Signature: _____ Date: _____

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Consent to Photograph

1. I hereby authorize Dr. Steven T. Constantine and/or his employees or associates to photograph me, take motion pictures, television pictures, videotape, electronic, digital or computer recordings or reproductions of me. (All of the aforementioned will be hereinafter referred to as photographic or electronic reproductions). This authorization includes the taking of photographic or electronic reproductions of any part of my body.
2. The photographs shall be used for my medical records, and if in the judgment of my physician, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which may deem proper in the interest of medical education, knowledge or research; however, provided that it is specifically understood that in any such publication or use I shall not be identified by name.
3. I authorize the use of any such photographic or electronic reproductions of me for any purpose, including by not limited to scientific or educational purposes, including publications or reproduction in all forms of media, whether public or private including the internet; however, provided that it is specifically understood that I shall not be identified by name. I understand that I may be identifiable from such photographic or electronic reproductions.
4. I understand that I may refuse to consent to the taking of photographic or electronic reproductions or that I may limit the taking or use of any such photographic or electronic reproductions without prejudice to my care. I do not impose any limitations except (list any limitations you wish to impose): _____

5. Unless the patient states otherwise in writing, this consent will be considered valid for the taking of all photographs or electronic reproductions for up to three years after the date of signing and it will not be necessary to obtain any further written consent for photographs or electronic reproductions during that three year period of time.
6. In any provision of this consent is held invalid or enforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

I understand all of the above information and have reviewed all of this material with my physician. All of my questions at this time have been answered.

Name: _____ **Signature:** _____ **Date:** _____

Witness: _____ **Date:** _____

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MINOR SOFT TISSUE SURGERY

I.V. AND GENERAL SEDATION ONLY

If you have elected to have I.V. sedation to make your surgery more comfortable and alleviate your fears, please follow these important instructions:

1. Do not eat or drink (including water) past midnight the night prior to your scheduled surgery. Our surgeries are scheduled for morning hours to make this fast easier on the patients. If for any reason your appointment must be late in the day, you may have liquid up to eight hours prior to your scheduled appointment.
2. A responsible adult must be available to accompany you. 24-hour care is necessary. You must make arrangements for a ride home.

ALL PATIENTS

The following instructions apply to all minor surgery patients including those undergoing I.V. sedation or local anesthetic:

1. Do not wear make-up, earrings or contact lenses the day of surgery. Leave your valuables at home.
2. Thoroughly wash the area to be treated the night prior to surgery and again just before coming for your surgical appointment. If a special soap is necessary, your nurse will provide it for you after you schedule your surgery date.
3. If you do take medicine each morning, take your normal medicine the day of surgery with a small sip of clear water. It is especially important that you take your blood pressure or heart medicines if you normally take those. Do not take any anti-inflammatory medicines (aspirin, Motrin, Celebrex, Vioxx, Ibuprofen, Naprosyn, Aleve, Advil, Excedrin, etc), or blood thinner medicines (Coumadin, Warfarin, etc.) FOR AT LEAST TWO WEEKS prior to your surgery. If you are unsure about a medication please call our office.
4. Extra-STRENGTH Tylenol will be sufficient for relief of any minor pain you may experience. Always report any rashes, itching or hives as they may be reactions to your medications. Discontinue use if any of these symptoms appear.

Patient Signature: _____ Date: _____

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Consent for Breast Augmentation Surgery

DATE: _____

PATIENT: _____

IMPLANT SIZE AND TYPE: _____

INCISION SITE: _____

I have elected to have breast enlargement surgery. Dr. Constantine has carefully explained the nature, goals, limitations and possible complications of the procedure to me. I have also had the opportunity to try on the breast implants and decide on the size.

I understand that there are risks and potential complications associated with augmentation surgery, as there are with any surgical procedure. Some of the risks and potential complications are extrusion of the implant, deflation or rupture of the implant, visible and palpable folds, fold failure, hematoma (bleeding), seroma (fluid collection), persistent pain, injury to the nerve supply of the nipple areolar complex causing sensory dysfunction (including hypersensitivity, hyposensitivity or even complete loss of sensation to the nipple that may never recover), asymmetry, uneven pockets, high-riding or low-riding implants, all of which may require re-operation and further expense. I understand that there may be pain associated with nerve entrapment or interference with muscle motion in the weeks following surgery. I understand that scar tissue (capsular contracture) may develop around the implant. In severe cases, it may be necessary to have the scar tissue removed. The amount of scar tissue that a patient develops cannot be determined prior to surgery. As with any surgery, I am aware that infection is possible and that if the infection cannot be treated by antibiotics, the implant may have to be removed and replaced after the infection is resolved.

I understand these potential complications, risks and other associated complications and risks to be real, and by signing this consent form I acknowledge my awareness and understanding of them. I also understand that further surgery may be necessary with the associated expenses of that medical and/or surgical management; including additional surgery, hospitalization, time off work and personal expenses. This process of breast augmentation is designed to enhance what I already have. No guarantees are made. Breasts, regardless of implants, will continue to change with age, pregnancy and lactation. I am aware that any discrepancy in the size of my breasts that is now present may not be completely corrected during the surgery. I have tried on the implants and have determined what I feel to be the difference in size. All risks have been explained and all questions have been answered to my satisfaction. I accept these risks with the hope of achieving my desired result.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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POST-OPERATIVE INSTRUCTIONS BREAST AUGMENTATION (BREAST SURGERY)

Diet:

It is very important to drink plenty of fluids.

Medication:

Take your pain medications as prescribed. Remember to have some food or milk in your stomach before taking pain medication. Do not take pain medication on an empty stomach. Pain medication is usually taken 1-2 pills every 4-6 hours as needed. This may vary from patient to patient. If you have taken pain medication and after 30 minutes to an hour and it has not helped the pain, or if you have any side effects such as a rash, itching or swelling, please notify us immediately. You need to remain alert, responsive and easily awakened. Remember pain pills DO NOT remove the pain; they only reduce it to make it tolerable.

Activity:

You may be up and walking as tolerated. Please walk at least 4 times a day to help minimize the risk of blood clot formation. You may be a little lightheaded or dizzy when upright. When getting up from a reclined position, sit at the side of the bed for about 5 minutes and take a few deep breaths before standing up. We would like you to mostly rest and take it easy the first day after surgery. You can resume your normal activities when instructed. Avoid heavy lifting for 2-3 weeks. Avoid raising your arms, vacuuming, etc. for the first 10 days. Please ask if you have questions about these limitations. Let pain be your guide. Avoid strenuous activities such as aerobics, golfing, etc. for 2 weeks, or until permission to do so is obtained.

General Anesthesia:

Because you have received general anesthesia today, DO NOT drive, operate hazardous machinery, make any major legal decisions or drink alcohol for 24-48 hours. The same applies while you are taking any narcotic pain relief medications. Also, a responsible adult must stay with you for the first 24 hours.

Complications:

Notify us if you have a fever greater than 102° F after 24 hours, if you have any abnormal drainage or if persistent nausea or vomiting occur. If you experience a sudden increase in pain, body temperature or swelling representing a collection of fluid, please call us immediately. Difficulty in breathing or shortness of breath is to be reported immediately. If you feel you are in need of emergency care, please go to the nearest hospital.

Special Instructions:

- (A) Swelling is normal. However, if you experience a sudden increase in pain, breast size or body temperature, please notify us immediately. You may call Dr. Constantine with any questions or concerns at 801.261.3637.
- (B) You may shower two days after surgery. NO BATHS for 2 weeks!
- (C) It is very important to have someone stay with you and help care for you for the first 24-48 hours after going home.
- (D) We need to see you again in the office 5-7 days following your surgery. Please call the office for the follow-up appointment if you have not already done so.

Signature: _____ **Date:** _____

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FINANCIAL POLICY REGARDING REVISION AND COMPLICATIONS

Every cosmetic and reconstructive surgeon has a few patients who will require revision or have some complications requiring additional surgery. As you have been or will be told, one cannot guarantee a result. In cosmetic procedures there are certain problems that will happen statistically no matter how well the care or how careful the doctor and team. Examples of problems that may be encountered are bleeding, and or unfavorable scar after a surgical procedure. In both of these cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of scarring). It is our policy as a predetermined courtesy to our patients not to charge a surgeon's fee for complications or revisional surgery within 12 months from the original surgery date. We do, however, expect the patient to pay whatever other expenses arise as a result of treatment in hospital or outpatient settings. If the revisional surgery occurs in our office facility, the patient is responsible for the expense of the facility and anesthesia.

A Breast Revision fee is \$800.00, in the case of a liposuction revision the fee is \$800.00. Abdominoplasty revision fee is \$800.00.

It is unlikely that a complication or revision procedure will be necessary in your case. However, no cosmetic surgeon can guarantee this to his patients. It is important for the patient undergoing an elective surgical procedure to understand this financial policy. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.

My signature below indicates that I understand and agree to the above policy.

Signature: _____ Date: _____

Witness: _____ Date: _____