

Brent D. Kennedy, M.D.

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** (clycyrrhiza 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 TO OPERATION FOR FAT TRANSFER

1. I hereby authorize Brent D. Kennedy, M.D. as duly qualified Maxillofacial Surgeon and such assistants as he may designate, to perform upon:

_____ An operation for the purpose of attempting to correct a deformity, improve function and/or improve by appearance, with respect to the following condition(s)

1. Facial Contour Deficiencies _____

2. I hereby swear that the operation(s) to correct the aforementioned condition(s) have been thoroughly explained to my satisfaction in addition, the specified risks involved have been explained and include, among others outlined, the following major complications:

- | | |
|--|---|
| 1. Bleeding/Bruising/Infection | 4. Incomplete masking of defect |
| 2. Migration and or resorption of fat transfer | 5. Damage to facial nerve/facial numbness/paralysis |
| 3. Over contouring/over correction of defect | 6. Reaction to meds or sutures/Phlebitis of I.V. site |

3. The Specific proposed operation(s), to which I agree to submit, is (are) as follows:

1. Harvest of Autogenous Body Fat from _____ area(s)
2. Fat Transfer (Injection) into _____ area(s) of the face

4. It has been explained to me, that during the course of such operation(s), unforeseen conditions may be revealed which necessitate either an extension of the aforementioned operation(s), or modified procedure(s) other than those specifically set forth in item 3. I therefore authorize, and do request, that Brent D. Kennedy, M.D., his assistants or designees, perform such surgical procedure(s) that are necessary and/or desirable in the exercise of professional judgment. This authority granted in this item shall also include treatment of all conditions that require such treatment and are not now known to Brent D. Kennedy, M.D. at the time the operation is commenced.

5. I furthermore know and understand that the practice of Medicine and Surgery is not an exact science, and that, therefore, reputed physicians cannot guarantee any specific results. No guarantee(s) or assurance has been given to anyone, by Brent D. Kennedy, M.D. or his staff, as to the expectations or results that may be achieved.

6. I consent to the administration of drugs and/or anesthetics applied by or under the direction of: **Brent D. Kennedy M.D.** And to the use of such anesthetic materials as he may deem advisable, I understand that the operating surgeons(s) will be occupied in performance of surgery, and that the administration of anesthesia and/or drugs is an independent professional function, as response of the aforementioned anesthesiologist, certified nurse anesthetist, or his designate.

7. My signature, or that of my legal guardian (minors) to this document will serve to acknowledge and approve items 1-6 above.

Patient Signature: _____ Date: _____

Witnessed: _____ Date: _____

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INFORMATION FOR FAT TRANSFER SURGERY

You have elected to have fat transfer surgery to correct contour deficiencies. Dr. Kennedy has explained the operation to you in detail and has answered all your questions. You should recall that problems are infrequent but may include: swelling, bruising, infection, numbness, and increased sensitivity of the skin. If you do not understand any of these potential risks please discuss them with Dr. Kennedy.

POST –OPERATIVE INSTRUCTIONS FOR FAT TRANSFER

1. Take pain and antiviral medication as necessary (prescription provided).
2. Complete your antibiotics as prescribed.
3. Minimize facial muscle movements ie, soft foods and limit chewing and talking for at least one week.
4. Avoid any pressure in the area of the mouth. A cold wet cloth can be applied to the area for the first 24 hours during waking hours to minimize swelling and bruising.
5. Wear compression dressing over fat donor site for 1 week Post Op.

CARE OF SKIN STITCHES

Supplies needed: Polysporin/Vaseline or Bacitracin ointment

Cotton – Tipped Applicators (Q-Tips, etc.)

3% Hydrogen Peroxide – fresh bottle

1. Mix 2 Tbsp. Peroxide with 2 Tbsp. tap water in a small container. Discard each time. **DO NOT** save mixture.
2. Use Q-Tips and peroxide solution to clean all blood and material from the incisions. **DO NOT** leave any crusts or blood on the stitched areas. Repeat a minimum of 4-5 times per day. **DO NOT** allow solution or ointment to get into eyes. Clean the incision from side to side, not up and down.
3. Cover ALL incisions and abrasions with a thin layer of ointment. **DO NOT** allow **ANY** area to dry out or scab over.
4. **DO NOT** apply any bandages or other materials to the surgical area unless otherwise instructed.
5. You may bathe or shower twenty-four hours after surgery. Dry the wound thoroughly and then apply ointment as directed.

PLEASE REPORT ANY OF THE FOLLOWING TO OUR OFFICE

- Sudden or excessive bleeding, swelling, or bruising.
- Any itching, rash, or reaction to medications.
- Fever, temperature over 100 degrees (taken orally).
- Discharge from the surgical site (other than blood).
- Any injury to the incision site.
- Loss of any stitches.

MY SIGNATURE VERIFIES THAT I HAVE RECEIVED/READ AND UNDERSTAND THE IMPORTANCE OF FOLLOWING THE ABOVE INSTRUCTIONS.

Patient Signature: _____ Date: _____

Sun Exposure Protect your facial skin from excessive sun exposure as long as the treated area(s) are still pink. When the treated area(s) are no longer pink, ordinary exposure is not harmful, but a sunscreen should always be used.

SPORTS No swimming, gym, or strenuous activities for two weeks. No diving or skiing for two months.

MEDICATIONS Pain Reliever - Take one tablet when you arrive home. Additional tablets may be taken every 4-6 hours as needed for pain relief. CAUTION: DO NOT DRIVE OR OPERATE MACHINERY WHILE TAKING PAIN RELIEVERS. Take with food or liquid to avoid nausea.

Sleep Medication – If prescribed, take one tablet 30-45 minutes prior to bedtime.

Antibiotics – If prescribed, you will be taking one tablet or capsule 2, 3 or 4 times a day. Take them until they are gone.

Aspirin – Avoid taking aspirin or aspirin containing compounds during your first week after surgery.

Anti-swelling – (Dexamethasone) If prescribed, take one tablet when you arrive home, and then again this evening. The remaining six should be taken morning, noon and night for the next two days. These will help reduce the amount of local swelling.

CARE FOR YOUR SKIN STITCHES

Supplies needed: Polysporin/Vaseline or Bacitracin ointment

Cotton – Tipped Applicators (Q-Tips, etc.)

3% Hydrogen Peroxide – fresh bottle

1. Mix 2 Tbsp. Peroxide with 2 Tbsp. tap water in a small container. Discard each time. **DO NOT** save mixture.
2. Use Q-Tips and peroxide solution to clean all blood and material from the incisions. **DO NOT** leave any crusts or blood on the stitched areas. Repeat a minimum of 4-5 times per day. **DO NOT** allow solution or ointment to get into eyes. Clean the incision from side to side, not up and down.
3. Cover ALL incisions and abrasions with a thin layer of ointment. **DO NOT** allow ANY area to dry out or scab over.
4. **DO NOT** apply any bandages or other materials to the surgical area unless otherwise instructed.

PLEASE REPORT ANY OF THE FOLLOWING TO OUR OFFICE

- Sudden fever >100 degrees (taken orally).
- Any unexpected pain.
- Any excessive itching, rash or adverse reaction to medication.
- Bleeding

FAITHFUL ADHERENCE TO PRE-OPERATIVE AND POST-OPERATIVE INSTRUCTIONS WILL HELP TO MINIMIZE SWELLING, PAIN AND DISCOMFORT. If you do have problems, please do not hesitate to contact our office for assistance. (801) 261-3637

I HAVE RECEIVED / READ AND UNDERSTAND THE IMPORTANCE OF FOLLOWING THE ABOVE INSTRUCTIONS.

Patient Signature: _____ Date: _____

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INSTRUCTIONS FOR CARE OF STITCHES

SUPPLIES NEEDED

- Bacitracin Ointment
- Cotton Tip Applicators (Q-tips)
- 3% Hydrogen Peroxide, Fresh Bottle

SUTURE LINE CARE

1. Mix 2 tablespoons peroxide with 2 tablespoons tap water in small container.
2. Use cotton tip applicators and peroxide solution to clean all blood and material from cuts. DO NOT leave any crusts or blood on stitched areas. Repeat for a minimum of 4 or 5 times per day.
3. Cover all cuts and abrasions with Bacitracin. Do not allow any area to dry out or scab over.
4. Do not apply any bandages or other materials unless otherwise instructed.
5. Do not use soap or shampoo near areas until instructed to do so.
6. Please clean areas thoroughly and apply Bacitracin just prior to any appointment. Make certain you have done your best – failure to do so is the most frequent cause of complications such as excessive scarring, wound infection and breakdown, etc.

IMPORTANT

Faithful adherence to post-operative stitch care will help to minimize swelling, discomfort and scarring. If you do have problems, do not hesitate to contact our office for assistance.

Patient 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, an unfavorable scar or body conformation 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 6 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 Surgery Revision fee is \$800.00 for the 1st area and \$500.00 for any additional area.

We hope that no complication arises and no revisional surgery is 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: _____