

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** (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 for Liposculpturing

Date: _____

Patient: _____

I hereby authorize Dr. Steven Constantine and any associates or assistants of his choice, to perform a liposculpturing procedure. I recognize that during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those explained. I, therefore, authorize and request Dr. Steve Constantine and associates, of his choice, to provide such procedures as are, in their professional judgment, necessary and desirable for my well-being. I further consent to the administration of such anesthesia as may be necessary or appropriate for such procedure. I understand that the proposed surgery/care may involve risks and possibilities of complications. I realize that even with the utmost care, judgment and skill, certain complications have been known to follow my procedure. I acknowledge that no guarantees have been made to me regarding the results of the operations/care, nor are there any guarantees against unfavorable results.

I clearly understand that there are potential complications and risks associated with liposculpturing. Although complications following liposculpturing are infrequent, I understand that the following may occur: Infection, hematoma, seroma, persistent pain, contour irregularities, skin slough, thrombophlebitis, pulmonary embolism, asymmetry, nerve damage and bowel perforation, all of which may require re-operation at further expense to the patient.

I also understand and accept the following: 1. The goal of a liposculpturing procedure, as in any cosmetic procedure, is improvement, not perfection. 2. The final result may not be apparent for 3-6 months post-operatively. 3. Areas of "cottage cheese" texture, i.e. "cellulite" will be changed little by the liposculpturing procedure, and might actually worsen. 4. Liposculpturing is a contouring procedure and is not performed for purposes of weight loss. 5. Strict adherence to the post-operative regimen discussed by Dr. Constantine is necessary in order to achieve the best possible results.

A touch up procedure is not always necessary. If you and Dr. Constantine feel that one is necessary, there will be an additional charge for the surgical facility and anesthesia, but Dr. Constantine will not charge you for his time.

I understand these potential complications and risks, as well as other related complications and risks, to be real, and by signing I acknowledge my awareness of them and that further surgery may be necessary with the associated expense of such medical and/or surgical intervention.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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PRE & POST-OPERATIVE INSTRUCTIONS

Liposculpturing

Pre-Operative

- *Do not eat or drink anything after midnight the night prior to surgery. No food, water, antibiotics, gum, candy, etc.
- *Do not take aspirin or ibuprofen-like (NSAIDS) containing products and/or diet pills anytime 2 weeks prior to surgery. These may cause bleeding problems, and surgery may be cancelled as a result.
- *Prior to surgery, wash with antibacterial soap. This will help to reduce the likelihood of infection.
- *You will be given a prescription for pain management. Narcotics do not eliminate the pain; they only help make it tolerable. Since narcotics and anesthesia can cause nausea, an anti-nausea prescription has been included. It is important to have an adult with you the first 24 hours after surgery to ensure your well being.
- *What to wear:

Pants: elastic-wasted, loose legged, preferably sweats, no jeans or dresses

Shirt: button or zipper all the way down the front

Shoes: slip-ons/flip-flops

No makeup, jewelry, nail polish and please do not bring anything of value.

- *You will undergo a general anesthetic. Therefore, you will need a responsible adult to drive you home and care for you over the next 24 hours.

Post-Operative

- *Dr. Constantine will see you in 1-7 days following your procedure. Do not remove the compression garment until after your postoperative visit. The compression garment should be worn at all times for 3-6 weeks.
- *Do not shower for 72 hours following the procedure.
- *It is common to drain a bright, clearish red fluid following liposculpturing.
- *Take your pain medication as prescribed. If you experience nausea or an allergic reaction, please notify the office and we will change your medication.
- *Avoid strenuous activities like aerobics, golfing, swimming, etc. for 6 weeks.
- *Avoid tanning beds until bruising completely disappears.
- *Swelling and bruising are normal. However, if you experience a sudden increase in pain, body temperature or collection of fluid pockets, please contact us immediately. If you have any questions or concerns please contact Dr. Constantine at 801.261.3637.

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, 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: _____