

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 Breast Lift (Mastopexy)

I hereby authorize Dr. Steven T. Constantine and any associates and assistants of his choice to provide the services listed above.

I clearly understand that the breasts may be of different size or shape. There may be discomfort or numbness of the breast or nipple, which could be permanent. There may be loss of tissue including all or part of the nipple, which could require further reconstructive surgery. Breast feeding may not be possible after surgery. Unsatisfactory scars may require revision, and breast shape may change with time requiring revision surgery. I acknowledge that no guarantees have been made to me as to the results of this procedure, nor are there any guarantees against unfavorable outcomes.

I understand these complications and risks, as well as the 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.

I recognize that during the course of the procedure, unforeseen conditions may necessitate additional or different procedures other than those explained. I, therefore, further authorize and request that my physician and any associates or assistants of his choice perform such procedures which are, in their professional judgment, beneficial to the outcome of the procedure.

I have read and understand this document and authorize and accept the proposed care regardless of the risks.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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POST-OPERATIVE INSTRUCTIONS

MASTOPEXY

ACTIVITY

1. You will need to rest frequently the first week. You may walk around the house as tolerated.
2. For the first week post-op sleep on your back with your head slightly elevated for comfort and to decrease swelling
3. Every 2-3 hours take deep breaths to expand your lungs.
4. Avoid picking anything up greater than 1-2 lbs the first week. The doctor will advise you when you can start lifting anything heavier.
5. Do not exercise until the doctor says you may do so.
6. You may not drive while you are taking pain medication
7. No housework until you are told otherwise.
8. No smoking or being around smoke at least the first 2 weeks after your surgery. This will interfere with your healing.

DIET

1. Eat light the first 24 hours, clear liquids advancing to a regular diet as tolerated.
2. If you have persistent nausea stick to a bland diet until it subsides
3. The pain medicine may cause constipation. Drink plenty of fluids. You may take any over the counter laxative as needed.

DRESSINGS

1. You will have a surgical bra over your dressings. You do not need to change them.
2. You may not shower the first week - sponge bathe only.
3. It is normal to see dried bloody drainage on the bra.
4. Bring a sports bra to your first post-op appointment. Preferably one that opens in the front to make it easier to put on.
5. After 2-3 weeks you may see little pimple-like blisters along the incisions. They are sutures that haven't yet dissolved. Your doctor will address those or any other issues you may have at your follow up visits.

MEDICATIONS

1. Take your antibiotic until it is completed.
2. If the pain medication is a narcotic it should be taken as prescribed.
3. Do not drink alcohol or drive a car while taking pain medication.
4. The pain medication may cause nausea and should be taken with food at each dose.
5. You may resume your regular medication after your surgery except for Vitamin E and Ibuprofen (wait at least 2 weeks post-op).
6. If you take aspirin or Coumadin check with the doctor to see when you may resume them.

CALL THE OFFICE AT (801) 261-3637 IF YOU HAVE:

1. A temperature greater than 101 degrees
2. Excessive bleeding from the incision.
3. A sudden increase in drainage, pain, or swelling around the incision site or the surrounding area.
4. If you have persistent vomiting, have a pharmacy number so that a prescription can be called in.
5. Any questions you may have regarding your care.

I certify that I have received these patient instructions.

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: _____