



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 (CO2 laser skin resurfacing / Sublative radiofrequency / IPL / Diode Hair removal 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, swelling, redness, bruising, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity or purpura 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 treatment may be painful, but this is typically manageable without any pain relief medication. I agree to receive local analgesic, sedative and amnestic medications before, during, and after the procedure for patient comfort and pain control. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, if 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 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 Ophthalmic 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

- **Hydrocodone with Acetaminophen 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) 5 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 (wash 4x/day): Obagi Purpose (OTC) Cetaphil (OTC)
- Occlusive Ointment (apply 4x/day for 3 days): Aquaphor ointment (OTC) Vasoline ointment (OTC) Elta MD Laser balm or kit Other:
- Non-Occlusive Moisturizer (apply on day 4): 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 for first 3 days
- Mineral Make-up: Glo Minerals after 7 days
- 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