PREPARING FOR YOUR PROCEDURE

DATE OF PROCEDURE: _____ ARRIVAL TIME: _____

PROCEDURE BEING PERFORMED: Upper Eyelid Blepharoplasty

PRE OP APPOINTMENTS: _____

POST OP APPOINTMENTS: _____

Do not take any aspirin or aspirin-containing products for at least 2 weeks prior to your surgery. Stop all blood thinners including fish oil, vitamin E, and ibuprofen. Please take Tylenol for a headache or pain. **** Stop alcohol at least one week prior to your procedure.**

Start your antibiotics the evening prior to the procedure. Take with food and a full glass of water, and follow instructions as directed on the bottle.

Someone ***must drive you home*** from the surgery. You also need someone to stay with you for the first evening. No exceptions allowed if your procedure requires pre-operative sedation for blepharoplasty.

Eat normal breakfast or lunch on the day of surgery. A **late snack is okay** if your surgery is at the end of the day. You want food in your stomach before the procedure.

Please wear comfortable clothing. Make sure that your shirt buttons or zips in the front and does not slip over your head. No one-piece outfits. Do not wear contact lenses. If you need to, bring prescription eyeglasses with you to wear.

Please take a shower and wash your hair on the morning of the day of surgery. **Do not wear make-up, perfume, aftershave, cologne, or jewelry.** Please leave valuables or personal items at home if they are not necessary for the surgery. **Bring sunglasses**.

Take all of your routine medications, as you normally would **EXCEPT any of your medications that we have told you to stop** (i.e. aspirin or Coumadin). Take blood pressure medications. Take food with any pain medication that you have been prescribed to minimize any stomach discomfort or nausea.

If you smoke, please limit or discontinue for at least one week post-op. Smoking impedes circulation and prolongs healing time.

Start Arnica pellets (dissolve under tongue) **7-14 days prior to procedure** to prevent bruising. You can start 2 weeks prior if you bruise heavily. Remember to stop all your blood thinners 2 weeks prior to the procedure (Tylenol is OK – if you need something stronger please ask the physician). You will continue to take arnica pellets after the procedure until suture removal.

Please contact the office, if you have any questions or concerns. Please identify yourself as a *"Cosmetic Eyelid Surgery Patient"* and that you need to speak with Dr. Chan.

MEDICATIONS TO AVOID PRIOR TO SURGERY OR PROCEDURES:

START: 5 Arnica pellets (3X/day) 1-2 weeks before procedure (reduces bruising)

NOTE: Arnica + Bromelain pills can be purchased here (1 tablet taken twice a day)

The following list includes the most common prescription and over-the-counter medications that can cause thinning of the blood. It does not include all possible medications. These medications should be stopped two weeks prior to your surgery date and, if prescription medications, any change in use must be cleared by your prescribing doctor. Please inform us of all medications you are currently taking including vitamins, herbals, over-the-counter, etc…

Most common blood thinners: Alcohol, Fish oil, Vitamin E, Aspirin, Ibuprofen

(NOTE: TYLENOL IS OK!)

Advil	Butazolidin	Emgrin	Meclomen	Salatin
Aggrenox	Cama	Empirin	Micranin	Saleto
Aleve	Carpon	Encaprin	Midol	Savaysa
Alka Seltzer	Cataflam	Equagesic	Mobidin	Sine-Off
Alcohol	Celebrex	Etodolac	Mobigesic	Solocol
Anacin	Celecoxib	Exedrin	Momentum	St. Joseph
Anaprox	Clinoril	Feldene	Motrin	Supac
Ansaid	Cope	Fiorinal	Nabumetone	Synalgos
Anturane	Co-Q10	**Fish Oil**	Nalfon	Tandearil
APAP Fort.	Coricidin	Flurbiprofen	Naprosyn	Tenstan
Argesic	CP-2	Garlic	Neocylate	Ticgrelor
Artha-G	Cosprin	Gaysal-S	Nuprin	Ticlid
Artholate	Coumadin	Gemnisyn	Oxalid	Ticlopidine
Arthropan	Dasin	Ginkgo	PAC	Tisma
Ascriptin	Diclofenac	Ginseng	Pabalate	Tolectin
Asper Buf	Dicumarol	Glucosamine	Pabirin	Tolmentin
Aspercin	Dipyridamole	Heparin	Panodyness	Toradol
Aspergum	Disalcid	**Ibuprofen**	Pepto-Bismol	Trental
Aspirin	Doans Pills	Indocin	Percodan	Trilisate
Asproject	Dolcin	Isollyl	Persantine	UracelS
Axotal	Dolobid	Kaopectate	Plavix	Vanquish
Bayer	Double-A	Ketoralac	Pradaxa	Vicoprofen
B C Tabs	Duoprin	Lanorinal	Presalin	Vimovo
Buffered aspirin	Duradyne	Lodine	Profen	**Vitamin E**
Buffaprin	Duragesic	Magan	Protension	Warfarin
Bufferin	Durasal	Magsal	Postel	Xarelto
Buffetts II	Dynosal	Marnal	Relafen	Zipsor
Buffinol	Ecotrin	Major-cin	Rivaroxaban	Zorpin
Buflex	Efficin	Majoral	Rufen	
Butal Comp	Eliquis	Measurin	Sal-Favne	

This is not mean to be a complete list but does list the most common blood-thinners. Also avoid any immune-suppressing medications including but not limited to: prednisone, infliximab, etanercept, alefacept, ustekinumab, methotrexate.

UPPER BLEPHAROPLASTY
POST-OP INSTRUCTIONS

Supplies Needed:

- **Frozen Peas or ice packs (as needed)**
- **Cetaphil or CeraVe Cleanser**
- **Q-Tips**
- **Aquaphor Ointment or Vaseline petroleum jelly**
- **Eye drops (artificial tears) – if you have dry eyes**
- **Arnica pellets (purchase at Amazon.com, Trader Joe's, Whole Foods, Sprouts)**
- **Antibiotics & pain medication (will be prescribed)**

- Frozen Peas may be applied for 5 minutes every hour while you are awake for the first week. First cover eyes with tissue or gauze, then apply peas over the treatment site and cheeks for the first few days to reduce swelling and pain.
- While sleeping, use an extra pillow to keep your head elevated for 7 days, or until the stitches are removed.
- You may experience swelling, pink drainage, and some mild bruising and may even notice your eyes swell shut. Swelling will be the worst the second day after the procedure. The bruising may become darker and more evident the days following the procedure and can be noticeable on the cheeks under the eyes due to gravity.
- You may shower and bathe as usual the next day. Wash over the stitches with a mild soap and water with your fingertips to remove and dried blood or crusting. Apply a thin layer of **Aquaphor Ointment** after showering.
- Keep a layer of Aquaphor Ointment over the stitches at all times using Q-tips (reapply every 1-2 hours). Remember to reapply after bathing & use frozen peas.
- When bending down to pick up anything, bend at knees and keep head up, rather than letting your head fall below the below level of the heart.
- Finish all antibiotics as directed. Take after eating a meal, with a full glass of water.
- Continue arnica pellets (5 pellets, three times a day) until suture removal.
- Apply eye drops (artificial tears) several times a day as needed for the first 1-2 weeks, if eyes feel dry after the procedure.
- If you take narcotic pain medication after the procedure, take only after eating with water to avoid nausea. Do not mix with alcohol. Do not drive if taking these. These medications may a make you constipated, so take stool softeners as needed.

Any questions or concerns about any excessive swelling, excessive itching, persistent bleeding, vision changes, asymmetry or the eyelids, or deep purple painful bruising, please call the office. When phoning after hours, please identify yourself as a *Cosmetic Eyelid Surgery Patient* to assure you are connected with the appropriate doctor.

Blepharoplasty Consent Form

I hereby authorize Dr. Joanna Chan and those she may designate as his assistants to perform upper eyelid blepharoplasty. I also authorize Dr. Chan and/or any associates to administer any anesthetic she may deem advisable for the above operation, treatment or procedure.

During the course of the operation, treatment or procedure, unforeseen conditions may be revealed that necessitate an extension of the original operation, treatment or procedure different operation(s), treatment(s), or procedure(s) than those set forth at the top of this consent form. I, therefore, authorize the physician, assistants, or designees to perform such operations, treatments, or procedures as are necessary and desirable in the exercise of professional judgment.

I am aware that possible complications of any surgical procedure include but are not limited to bleeding, infection, pain, scarring, alteration of the skin color, contour or texture, sensation or nerve damage, muscle weakness, recurrence of the lesion or disease, need for further treatment, and inadequate result. I understand that on occasion, after healing, a secondary procedure or revision may be recommended in order for me to obtain the best cosmetic result. No guarantees can be made regarding my satisfaction of the cosmetic results following the procedure. I understand that I have the option to seek a plastic surgeon.

Additional risks and consequences associated with the above-noted procedures and anesthesia include but not limited to:

- Eye, Eyelid Injury
- Hematoma
- Asymmetry
- Dry Eyes
- Blindness
- Lid Damage
- Altered vision
- Corneal Injury

I consent to and request that Dr. Chan take possession of any tissue or parts removed.
I further agree that any pictures or videotape taken of me can be used for either teaching or publication, as Dr. Chan considers appropriate unless I notify her in writing that my photographs are not to be used under such circumstances.

This procedure is generally considered cosmetic and thus not covered by insurance. I understand that I am responsible for all costs of treatment, including the portion of the cost not covered by insurance. By signing below, I acknowledge that I have read and understand the above information in full.

I certify that I have read or have read to me, the contents of this form. I understand the risks, benefits and alternatives involved in this procedure. The nature and purpose of this procedure, with possible alternative methods of treatment as well as the risks, benefits, and possible complications have been fully explained. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. No guarantee has been given regarding cosmetic satisfaction or the particular results that can be achieved by this treatment.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Patient Photographic Consent Form

I hereby consent to the taking of photographs and/or video of me or parts of my body ("Materials") and grant Joanna Chan, MD and/or her designee permission to publish, distribute, and otherwise use such Materials in any and all of its publications. I understand & agree to transfer any and all rights I may have in and to these Materials, and that they will become the property of Joanna Chan, MD and will not be returned. I understand that the Materials may be published by Joanna Chan, MD or a third party in any print, visual or electronic media, specifically including, but not limited to, newspapers, magazines, medical journals & textbooks, pamphlets and the Internet, for the purpose of informing the medical profession or the general public about dermatologic surgery and/or dermatologic surgery methods.

I hereby irrevocably authorize Joanna Chan, MD to edit, alter, copy, exhibit, publish or distribute these Materials for purposes of publicizing Joanna Chan, MD's services or programs or for any other lawful purpose including, but not limited to medical purposes, scientific purposes (e.g., seminars, medical articles or educational presentations, websites), before-and-after photo album (digital or printed) for cosmetic patients to view in office, included in a newsletter, or a website. Permission is specifically granted for the work to be edited, altered, used in whole or in part, in conjunction with other images, graphics, text and sound in any way whatsoever and without restrictions in any way that Joanna Chan, MD and/or her designee(s) may consider appropriate to achieve the purposes for which, or comply with the limitations subject to which, this consent is given.

In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness or altered likeness appears. I understand that the Materials may portray features that may identify or otherwise present a recognizable likeness of me. I understand that the Materials, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized re-disclosure, & the information may not be protected by applicable federal and/or state confidentiality rules.

Additionally, I waive any right to royalties or other compensation arising from or related to the use of any Materials and understand that the copyright to all Materials is retained by Joanna Chan, MD. The photographer shall own all Material rights, which shall accrue to the benefit of his/her successors, legal representatives and assigns. Joanna Chan, MD need not approach me again for authorization to use these Materials. I hold Joanna Chan, MD and her designees harmless from any liability related to use of these Materials for the purposes outlined above. I hereby hold harmless and release and forever discharge Joanna Chan, MD and her designees from all claims, demand and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of me signing this Patient Photographic Consent Form.

I am competent to contract in my own name and grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above and fully understand its terms.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

PATIENT PROCEDURE CHECKLIST

Please initial the following: Initials

- The doctor, nurse and cosmetic consultant answered all my questions about my procedure, and I know how to contact them if I have any further questions.

_____

- I understand that each individual may have a different degree of improvement.

  _____

- Dr. Chan has reviewed all potential risks with me.

  _____

- I have a written cost estimate and agree to pay the quoted amount in full before the date of my procedure.

_____

- I have received reading materials about my procedure. I understand how to prepare for my procedure and how to care for myself after my procedure.

  _____

- I have received my prescriptions and understand how to take them.

  _____

- I agree to have my pictures taken before and after my procedures.

  _____

- I agree to let my pictures be viewed by other patients who wish to have a similar procedure.

_____

- I have signed my consent forms.

  _____

- I will have a ride and a caregiver arranged.

  _____

- I have received my eye exam request form and will have this paper processed and faxed to the doctor's office. My procedure will be cancelled and deposit forfeited if this form is not received.

_____

- I have stopped taking fish oil, ibuprofen, aspirin and vitamin E at least 2 weeks prior to my procedure date.

  _____

- I have stopped alcohol one week prior to my appointment.
  _____
- I have had an eye exam and had results faxed to the doctor's office.
  _____

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Cosmetic Surgery Questionnaire

This questionnaire is designed to provide us with your relevant medical history and additional information required for a comprehensive evaluation and treatment recommendation. Please answer all questions to the best of your knowledge.

NAME: _____ AGE:_____

OCCUPATION: _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

ADDRESS / PHONE #:_____

DO YOU HAVE ANY MEDICAL PROBLEMS? (circle all that apply)

DIABETES	**HIGH BLOOD PRESSURE**	**HEART DISEASE**
LIVER DISEASE	**HEPATITIS**	**HIV OR AIDS**
STROKE	**ARTIFICIAL VALVE OR JOINT**	**KIDNEY DISEASE**
ARRYTHMIAS	**MITRAL VALVE PROLAPSE**	**KELOIDS / BAD SCARS**
LUPUS	**HISTORY OF STAPH INFECTION**	**OTHER (LIST BELOW)**

OTHER: _____

Any allergies to medications, local anesthetics, or topical medications? ___Yes ___No

History of depression, anxiety or psychiatric illness requiring medication? ___Yes ___No

Do you smoke? _____Yes _____No Have you every smoked? ___Yes ___No

If yes (present or past), how many packs per day? _____

When did you start/stop? _____

Do you drink alcohol? ____Yes ____No If yes, how frequently? _____

Do you need prophylactic antibiotics before seeing the dentist or having surgery? ___Yes ___No

If yes, what is the name of the medication and the dosage? _____

Please list any additional issues you would like to discuss:

_____

_____

_____

SURGERY PRICE QUOTE

PATIENT NAME: _____ DOB: _____

I understand that the procedure(s) listed below are not considered medically necessary. Therefore, the charges will not be billed to my insurance company and are completely my responsibility.

PROCEDURE

Upper Eyelid Blepharoplasty	**$3750**
***SURGERY CENTER FACILITY FEE**	**Waived**
TOTAL	

The office requires a minimum $1000 deposit to reserve and schedule the procedure(s). The remaining balance will be collected at the pre-operative appointment approximately one (1) week prior to the surgery.

Visa, MasterCard, Cash, Money Order or Certified checks are accepted forms of payment. If you do wish to pay with a personal check, the procedure must be paid in full at least 2 weeks prior to the scheduled surgery date.

If you wish to cancel your procedure after the pre-operative appointment, the office will retain the $1000 deposit but will refund any additional monies that have been paid.

Additionally, if the procedure is cancelled less than 48 hours prior to the scheduled surgery date the office has the right to retain all monies paid. The procedure may be rescheduled only up to two (2) business days prior to the originally scheduled appointment. If rescheduled with less than two business days notice, the original deposit is forfeited, and another deposit must be paid before being placed back on the schedule.

The patient is financially responsible for all cosmetic procedures. There are no refunds after procedure is complete. This office does not bill insurance companies for cosmetic procedures. In the rare event the procedure is billed to insurance, you are responsible for any amount the insurance does not pay. This may include the full fee of the procedure.

A copy of this form will be kept in your file for record keeping purposes. All price quotes are guaranteed for 6 months.

*****Any refunds will be minus a 5% processing fee regardless of form of payment*****

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Upper Blepharoplasty Preoperative Clearance

Patient Name: _____

Date of Birth: _____

Date: _____

Dear Doctor:

The patient listed above has elected to have an upper blepharoplasty with Dr. Joanna Chan. The procedure is a local anesthesia procedure. In order for the patient to undergo this procedure, we request a recent eye examination within the past year from an optometrist or ophthalmologist to ensure no abnormal conditions of the eye. If the patient has a dry eye condition, please indicate the severity below, as less skin will be removed during the procedure.

Dr. Joanna Chan is a fellowship trained Mohs Micrographic Surgeon and cosmetic surgeon who has attended Harvard, Stanford, UT Southwestern Medical Center, and California Skin Institute for fellowship, training under Dr. Greg Morganroth. She has performed and assisted on hundreds of similar cosmetic procedures, and she is conservative in her approach to prevent complications. Please contact our office directly if you would like to speak with her to learn more about her training and results.

If the patient does not have any contraindications to the procedure at the time of their last examination with you, please indicate with your signature below and **attach clinical notes from their last visit** and fax back to our office.

FAX: 626-449-4504
ATTN: JOANNA CHAN, MD

_____ _____

Printed Name / Title Signature / Date

Thank you. Please call me if you have any questions.

Sincerely,

Joanna Chan, MD