

Patient Name: _____ Date: _____

Surgery Date: _____

Once your surgery is completed, you must follow all the instructions given to you in order to heal properly and have a good outcome.

The following instructions are your obligation. Use this as a checklist of progress as you heal. Included are normal post-surgical experiences and key health considerations that may be a cause of concern.

NORMAL POST-OPERATIVE SYMPTOMS

Whether this is your first procedure or a subsequent autologous fat injection treatment, follow these instructions precisely:

- **If your injections are facial, do not bend over or lay flat following treatment.** This may increase any swelling you may experience. Sleep with your head elevated for the first few days following treatment.
- **If your lips have been injected, avoid pursing your lips for the first few days after injection.** This means sipping from a cup rather than a straw, and no pursing a cigarette.

The following are normal experiences that can occur following treatment:

- Tenderness or bruising at the injection site may last a week or more.
- Redness and swelling are likely and may take 2 to 4 weeks or more to resolve.
- Asymmetry is possible: Opposite sides of your face, and different facial regions may react differently including swelling and bruising. This is normal. If asymmetry is severe, is accompanied by acute localized pain, or is not corrected within 7-10 days following your injection, contact our office immediately.
- If you develop any nodules, lumps or uneven appearance in the skin, please call our office immediately.

*** IF THIS IS YOUR FIRST TREATMENT**

You may also experience mild tenderness, swelling, bruising or discomfort at the site where fat was extracted prior to your injections. Treat these conditions in the same manner you will treat the fat injection sites.

To alleviate any discomfort, and to reduce potential swelling you may gently, and without pressure, apply cool, not cold compresses to the treatment site. Crushed ice or ice packs must be wrapped in a towel before being applied to the skin. Do not apply ice or anything frozen directly to the skin. Apply cool compresses for no longer than 20-minute intervals.

DAY OF THE TREATMENT INSTRUCTIONS

You will only be released to the care of a responsible adult. All of these instructions must be clear to the adult who will monitor your health and support you, around the clock in your first days home from the hospital.

_____ **Rest, but not bed rest:** While rest is important in the early stages of healing, equally important is that you are ambulatory: meaning that you are walking under your own strength. Spend 10 minutes every 2 hours engaged in light walking indoors as you recover.

_____ **Recline, do not lie down.** This will be more comfortable for you, and can reduce swelling. Always keep your head elevated. Do not bend forward or over.

_____ **Good nutrition.** Fluids are critical following surgery. Stick to non-carbonated, non-alcoholic, caffeine-free and green tea-free beverages including fruit juices and water, milk and yogurt drinks. You must consume at least 8 ounces of fluid every 2 hours. Stick with soft, bland, nutritious food for the first 24 hours.

_____ **Take all medication, exactly as prescribed:** Oral pain medication, antibiotics and other medications you must take include:

| | | |
|----------------------------|----|-----------|
| Antibiotic | mg | x per day |
| Pain Medication | mg | x per day |
| Other / Supplements | | |
| | | |
| | | |

_____ **Keep your injection and donor sites clean.** Injection sites may seep fluid and some blood for a short time after surgery. A cotton swab or gauze soaked in warm water is appropriate for cleansing.

_____ **Do not smoke.** Smoking can greatly impair your safety prior to surgery and your ability to heal following surgery. You must not smoke.

_____ **Relax.** Do not engage in any stressful activities. Do not lift, push, or pull anything. Take care of no one, and let others tend to you.

TWO (2) TO SEVEN (7) DAYS FOLLOWING TREATMENT

During this time you will progress with each day that passes. Ease into your daily activities. You will receive clearance to begin driving or return to work at your post-operative visit, or within _____ **days.**

Your post-operative visit is scheduled for: _____.

- **Cleanse your skin as directed. You may shower.** Take a warm, not hot shower. If you choose to use a hair dryer, use only the coolest setting and do not allow the compressed air to blow directly onto your face or other treated areas.
- **Apply ointment and skincare as directed.** Do not use any glycolic, retinoid or other potentially irritating skincare products on your face until you receive clearance to do so.
- **Take antibiotic medications and supplements as directed.** Take pain medication only as needed. You may wish to switch from prescription pain medication to acetaminophen or ibuprofen.
- **Protect treated areas from sun exposure. Wear dark lens, large framed sunglasses and a wide-brimmed hat whenever you are outdoors.** Wear an SPF 30 daily on both the treated area and the donor site.
- **Continue to keep your head elevated, including when sleeping.**
- **Do not resume any exercise other than regular walking.** Walking is essential every day to prevent the formation of blood clots.
- **Maintain a healthy diet. Do not smoke. Do not consume alcohol.**

ONE (1) TO FOUR (4) WEEKS FOLLOWING TREATMENT

As you resume your normal daily activities, you must continue proper care and healing.

- **Refrain from direct sun exposure.** Continue to wear your sunglasses and a wide-brimmed hat. If you are outdoors, apply at least an SPF 30 at least 30 minutes prior to sun exposure. The injected region and donor site are both highly susceptible to sunburn or the formation of irregular, darkened pigmentation.
- **Do not smoke.** Smoking deprives your body of necessary oxygen that can result in poor healing.
- **You may ease into your regular fitness routine when you feel ready.** However protective eyewear and a hat are necessary when outdoors.
- **You may begin sleeping in a modified reclining position.** However do not sleep lying flat or on your stomach. If you are a side sleeper, two pillows under your head and a soft pillow under your mid-back and shoulders may offer more comfort.

Follow-up as directed. Your second post-operative visit is scheduled for: _____.

SIX (6) WEEKS FOLLOWING SURGERY

Healing will progress; swelling continues to diminish.

- **Follow-up treatment varies. Autologous fat is considered a permanent filler. However, some of the initial volume of fat injected will reabsorb and you may desire additional injections to achieve your results. Your results may be achieved following one treatment session. You may require more touch-up treatments or a subsequent injection session to achieve your final results. For this reason, some of your fat may be frozen and stored to use in subsequent treatments.**
- **No need to resume smoking.** You have now gone 10 weeks (4 weeks prior to surgery and 6 weeks following) without a cigarette. For your long-term health, there is no need to resume smoking.

YOUR FIRST YEAR

- **Continue good skincare and sun protection, healthy nutrition and fitness.**
- **Schedule any complementary procedures, as recommended.** Botulinum injections or specific skincare treatments may be recommended to enhance your results, and to help your results to be long-lasting.
- **A one-year post treatment follow-up is recommended.** However, you may call our office at any time with your concerns or for needed follow-up.

Your appearance will change with age. Your facial appearance may change too. You may wish to undergo additional injections or procedures at a later date to help maintain your appearance throughout life. Contact our office with any of your questions or concerns, at any time.

I have read and understand all of the above instructions. I understand that following these instructions is solely my responsibility. I understand that it is also my responsibility to ask my doctor and his or her staff any questions I have related to these instructions or about my procedure, health and healing.

Patient Signature: _____ **Date:** _____

Printed Name of Patient: _____

Signature of Practice Representative and Witness: _____