# PRE-TREATMENT INSTRUCTIONS: SCAR REVISION NON-SURGICAL

Patient Name _____ Date _____

Successful treatment requires a partnership between you and _____,MD

The following instructions are essential to a safe experience and good outcome. Use this as a checklist as you approach your surgery date. If you are unable to comply with these instructions, you must notify our office as soon as possible. As a result, your surgery may have to be postponed or delayed, at the judgment of _____, MD This is essential to your health and safety.

## THREE WEEKS OR MORE BEFORE TREATMENT

There may be several weeks between your decision to undergo treatment and the actual dates for treatment, or when your treatment will begin. During this time there are several important considerations:

_____ **Avoid Sun Exposure:** Sun exposure can greatly affect the outcome of your procedure. Avoid any direct sun exposure to the area which will be treated and wear a SPF 30 daily even if the region to be treated is covered by clothing.

_____ **Stop smoking:** Smoking can greatly impair your ability to heal.

_____ **Pre-operative testing:** Make certain to schedule all of the pre-operative testing and clearance you have been given. Refer to the ***Pre-surgical Lab and Testing Orders*** form. Make certain all test results are received by Dr. _____ as required.

## PRIOR TO YOUR TREATMENT

_____ **Purchase ointment or other items as recommended.**

_____ **Fill your prescriptions and take/apply them according to the instructions you are given.** Our office will advise you accordingly. Your prescriptions include:

| | | | |
|---|---|---|---|
| | _____ | _____ mg | _____ x per day |
| Topical | _____ | _____ mg | _____ x per day |
| Topical | _____ | _____ mg | _____ x per day |
| Other | _____ | _____ | _____ |
| Supplements | _____ | _____ | _____ |
| | _____ | _____ | _____ |

_____ **STOP taking or using the following no less than 2 weeks before your treatment:**

- ☐ Aspirin and medications containing aspirin
- ☐ Ibuprofen and anti-inflammatory agents
- ☐ Vitamin E
- ☐ St. John's Wort
- ☐ Gingko
- ☐ Garlic Supplements
- ☐ Green Tea or green tea extracts
- ☐ Retinoids
- ☐ All other medications indicated

_____ **NO SUN EXPOSURE:** Your procedure may have to be post-poned if you have any tan at all. The need to post-pone your procedure may ***be at your cost.***

**THE DAY OF YOUR TREATMENT**

_____ **Dress appropriately.**

- **Do not wear cosmetics, jewelry of any kind, or body piercing in the area of the scar to be treated.**
- **Wear comfortable, clean, loose-fitting, non-irritating clothing in the area of the scar to be treated.** If the scar is located on your face or scalp, wear a wide-brimmed hat**.**

**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