GOALS®
AESTHETICS & PLASTIC SURGERY

Pre Op Instruction Booklet

YOU MUST ARRIVE ONE HOUR PRIOR TO YOUR SCHEDULED SURGERY TIME OR SURGERY WILL BE RESCHEDULED.

ARRIVAL TIME AND **DAY OF SURGERY**

- Must be accompanied and picked up by an adult over the age of 18 years old. If you do not come with responsible adult, you will be rescheduled with a $500 RESCHEDULING FEE.
- Take a shower the night before and the morning of your surgery. Scrub thoroughly with your germ-inhibiting soap. Shampoo your hair the morning of surgery.
- DO NOT use makeup, creams, lotions, hair gels, sprays, perfumes, powder, or deodorant on your skin, hair, or face.
- DO NOT wear contacts to surgery. Wear your glasses and bring your glasses case.
- Wear comfortable loose-fitting clothes: We recommend a button-up top and pull-on pants with easy-to-slip-on flats. Don't wear a shirt or other clothing that has to be pulled over your head.
- Do not bring any jewelry or personal belongings. Goals is in no way responsible for any lost, missing, stolen or damaged items.
- If you are on your menstrual cycle please have a tampon on for your procedure
- Please arrive at least 60 minutes before your scheduled surgery time.
- You must wear a face mask and arrive on time.
- We will go over your contract, and any applicable consent forms.
- We will go over your procedure, and answer any questions you may have.
- Medication will be given to you as well.

Patient Initial _____

MEDICATION

- Medications are <u>sent the day prior to your surgery date to the pharmacy we have on file</u>. If you have not provided us with your preferred pharmacy, please do so immediately. Please note, only major 24 hour pharmacies are allowed. Medications are typically ready for pick up by 5 PM EST the day prior to your procedure.
- You must bring all the medications your surgeon sent to the pharmacy with you to surgery, no medication will incur a charge of $**150 No-Medication Fee**.
- **Night Before**. Only your antibiotics are to be taken the night before surgery and every 12 hours until medication is finished.
- **Bring all your prescribed medications with you on the day of your procedure.**
- Upon your arrival, we will administer the rest of the medication to you. These medications must be taken under supervision, to document date and time of administration.

Patients may be able to download the GoodRx *Mobile App* for discounted pricing on medications.

Patient Initial _____

HOME CARE

- Place **Disposable Underpads** on bedding post-surgery. Also, purchase **Surgical Tape and Gloves** for changing dressings.
- **Do not wipe incision sites** with or use any cleansers. Keep your dressings as clean and dry as possible. Do not remove them unless instructed to do so.
- **Do not remove sterile strips,** they will fall off on their own.
- **No showering** for 48 hours after your procedure.
- **Supervision.** If you are going home, a family member or friend (a responsible adult) must drive. Someone should stay overnight with you, if possible.
- **No smoking.** Smoking reduces the capillary flow in your skin. We advise you not to smoke at all during the first 6 weeks after surgery.
- **Diet.** If you have any postoperative nausea, carbonated sodas and dry crackers may settle the stomach. If nausea is severe, use a suppository. If you feel normal, start with liquids and bland foods, and if those are well tolerated, progress to a regular diet.
- **IMPORTANT: Call our office +1 (833) 462-5769 (24/7 Hotline) at any time if you are to:**
  - If you develop a fever (100.4 Fahrenheit or greater)
  - If you see unusual redness, unusual inflammation, any area hot to the touch, any discharge yellow or green in color
  - If you notice any foul odor, or any sudden increase in pain or tenderness.

Patient Initial _____

THIS ARBITRATION PROVISION LIMITS YOUR RIGHTS, INCLUDING YOUR RIGHT TO MAINTAIN A COURT ACTION. PLEASE READ IT CAREFULLY PRIOR TO SIGNING.

I HAVE BEEN GIVEN A COPY OF THIS PREOPERATIVE INSTRUCTION FORM FOR MY RECORDS AS WELL AS THE PATIENT INFORMATION BOOKLET. I HAVE READ THIS AGREEMENT IN ITS ENTIRETY; I UNDERSTAND THE RULES AND REGULATIONS CONTAINED IN THIS AGREEMENT AND AGREE TO BE BOUND BY THE SAME.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

NOVEL CORONAVIRUS (COVID-19) SCREENING QUESTIONNAIRE

To protect everyone, including staff, and follow CDC guidelines we are asking all visitors to complete the following questionnaire.

Have you in the past 3-14 days:

1. **Traveled to and/or from one the affected countries or regions?** As of March 2020, those countries are — Europe, China, Iran and South Korea.

_____ Yes _____ No

2. **Been in contact with a Novel Coronavirus (Covid-19) infected person without wearing appropriate PPE?**

_____ Yes _____ No

3. **Have you had the following symptoms in the last few days?** Felt unwell, especially with respiratory symptoms (cough, high temperature, shortness of breath, difficulty breathing)

_____ Yes _____ No

Note: If you pass the screening you will still be required to wear a mask upon arrival to the surgery center.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

SMOKING ATTESTATION FORM

Please fill this form out in its entirety. All patients wanting to receive a procedure from Goals Plastic Surgery must complete this form before surgery is performed.

TOBACCO USE STATUS (Please check one)

_____ I do not use tobacco and/or nicotine products and promise not to use tobacco products during this benefit year. I understand that I may be subject to tobacco use testing.

_____ I currently use tobacco and/or nicotine products. I understand that 6 weeks before my scheduled surgery date, I **MUST STOP THE USE OF ANY TOBACCO AND/OR NICOTINE PRODUCTS**. I understand that failure to stop the use of such products will result in the cancellation of my procedure, the assessment of a $1500.00 cancellation/rescheduling fee that MUST be paid before surgery can be rescheduled.

A tobacco user is defined as an individual who has used tobacco products (including but not limited to, cigarettes, cigars, e-cigarettes and/or chewing tobacco) during the past six (6) months.

Please Sign Below:

I understand that this is a legally binding document and I attest that the above information is accurate and correct. This attestation form is not complete unless I have checked a box in the Tobacco Use Status section that is relevant to me and have signed and dates the form below.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

FOR PATIENTS UNDERGOING ABDOMINOPLASTY (TUMMY TUCK) AND/OR BREAST AUGMENTATION:

TYPE OF ANESTHESIA (For Internal Use)

_____ **GENERAL ANESTHESIA (FULLY SEDATED)**

★ **No eating or drinking 8 to 10 hours before your scheduled surgery time.**
★ Take the antibiotics you are prescribed, 12 hours before your procedure.
★ Bring all your prescribed medications with you to the surgery center on your surgery date.

_____ **LOCAL ANESTHESIA**

★ **Eat a light meal prior to your procedure.**
★ Take the antibiotics you are prescribed, 12 hours before your procedure.
★ Bring all your prescribed medications with you to the surgery center on your surgery date.