



**FARAHMAND  
PLASTIC SURGERY**

**Home Care Instructions- Blepharoplasty**

1. Rest in bed as much as possible for the first 24 hours. Sleep with your head elevated on 2-3 pillows or in a reclining chair to help reduce swelling for 5-6 days.
2. Cold compresses may be used to help swelling for the first 24 hours, ½ hour on and ½ hour off.
3. Do not wash your eyes. Apply Bacitracin Ophthalmic Ointment to sutures twice daily. Puralube inside eyes at bedtime to prevent dryness (until eyes are able to close completely). Celluvisc inside eyes during daytime to prevent dryness.
4. Do not bend over or do any strenuous exercise for 2 weeks.
5. You may want to wear dark glasses to protect your eyes from the wind and sun. Be sure that the nosepiece does not irritate your eyes.
6. Do not drive for 1 week.
7. Do not wear make-up for the first week. Dr. Farahmand will instruct you as to when you can resume wearing make-up.
8. Report any fever or chills, any adverse reactions to medications or unusual symptoms immediately to Dr. Farahmand. If you have any questions or problems, please don't hesitate to call our office: 332-2388.
9. **Do not take any aspirin products, ibuprofen, or vitamin E until approved by Dr. Farahmand.** Medications for pain relief and antibiotics with directions will be given to you. Take all medications as prescribed, pain medications should be taken with food.

Additional  
Info: \_\_\_\_\_

Your next visit is: \_\_\_\_\_

\_\_\_\_\_

Date

\_\_\_\_\_

Responsible Person/Patient

\_\_\_\_\_

Witness

# INFORMED-CONSENT-BLEPHAROPLASTY SURGERY

## INSTRUCTIONS

This is an informed-consent document which has been prepared to help your plastic surgeon with inform you concerning blepharoplasty surgery, its risks, and alternative treatments.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your plastic surgeon.

## INTRODUCTION

Blepharoplasty is a surgical procedure to remove excess skin and muscle from both the upper and lower eyelids along with underlying fatty tissue. Blepharoplasty can improve drooping skin and bagginess. It can help improve vision in older patients who have hooding of their upper eyelids. Although it can add an upper eyelid crease to the Asian eyelid, it will not erase evidence of one's racial or ethnic heritage. Blepharoplasty will not remove "crow's feet" or other wrinkles, eliminate dark circles under the eyes, or lift sagging eyebrows.

Blepharoplasty surgery is customized for every patient, depending on his or her particular needs. It can be performed alone involving upper, lower or both eyelid regions, or in conjunction with other surgical procedures of the eye, face, brow, or nose. Eyelid surgery cannot stop the process of aging. It can however, diminish the look of loose skin and bagginess in the eyelid region.

## ALTERNATIVE TREATMENTS

Alternative forms of management include of not treating the skin laxness and bagginess in the eyelids by surgery. Improvement of skin laxness, fatty deposits and skin wrinkles may be accomplished by other treatments or surgery such as a brow lift when indicated. Other forms of eyelid surgery may be needed should you have disorders affecting the function of the eyelid such as drooping eyelids from muscle problems (eyelid ptosis) or looseness between the eyelid and eyeball (ectropion). Minor skin wrinkling may be improved through chemical skin-peels or other skin treatments. Risks and potential complications are associated with alternative forms of treatment.

## RISKS of BLEPHAROPLASTY SURGERY

Every surgical procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo a surgical procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your plastic surgeon to make sure you understand the risks, potential complications, and consequences of blepharoplasty surgery.

**Bleeding**- It is possible, though unusual, to have a bleeding episode during or after surgery. Bleeding may occur under the skin or internally around the eyeball. Should you develop post-operative bleeding, it may require emergency treatment or surgery. Do not take any aspirin or anti-inflammatory medications for ten days before surgery, as this may contribute to a greater risk of a bleeding problem. Hypertension (high blood pressure) that is not under good medical control may cause bleeding during or after surgery. Accumulations of blood under the eyelids may delay healing and cause scarring.

**Blindness**- Blindness is extremely rare after blepharoplasty. However, it can be caused by internal bleeding around the eye during or after surgery. The occurrence of this is not predictable.

**Infection**- Infection is very rare after surgery. Should an infection occur, additional treatment including antibiotics may be necessary.

**Scarring**- Although good wound healing after a surgical procedure is expected, abnormal scars may occur both within the eyelid and deeper tissues. In rare cases, abnormal scars may result. Scars may be unattractive and of different color than surrounding skin. There is the possibility of visible marks in the eyelid or small skin cysts from sutures. Additional treatments may be needed to treat scarring.

## Risks of Blepharoplasty Surgery, continued

**Damage to deeper structures-** Deeper structures such as nerves, blood vessels, and eye muscles may be damaged during the course of surgery. The potential for this to occur varies with the type of blepharoplasty procedure performed. Injury to deeper structures may be temporary or permanent.

**Dry eye problems-** Permanent disorders involving decreased tear production can occur after blepharoplasty. The occurrence of this is rare and not entirely predictable. Individuals who normally have dry eyes may be advised to use special caution in considering blepharoplasty surgery.

**Asymmetry-** The human face and eyelid region is normally asymmetrical. There can be a variation from one side to the other following a blepharoplasty surgery.

**Chronic pain-** Chronic pain may occur very infrequently after blepharoplasty.

**Skin disorders/skin cancer-** A blepharoplasty is a surgical procedure to tighten the loose skin and deeper structures of the eyelid. Skin disorders and skin cancer may occur independently of eyelid surgery.

**Ectropion-** Displacement of the lower eyelid away from the eyeball is a rare complication. Further surgery may be required to correct this condition.

**Corneal exposure problems-** Some patients experience difficulties closing their eyelids after surgery and problems may occur in the cornea due to dryness. Should this rare complication occur, additional treatments or surgery and treatment may be necessary.

**Unsatisfactory result-** There is the possibility of a poor result from eyelid surgery. Surgery may result in unacceptable visible deformities, loss of function, wound disruption, and loss of sensation. You may be disappointed with the results of surgery. Infrequently, it is necessary to perform additional surgery to improve your results. Additional surgical procedures such as a browlift may be needed to correct eyebrow sagging which contributes to upper eyelid problems.

**Allergic reactions-** In rare cases, local allergies to tape, suture material, or topical preparations have been reported. Systemic reactions which are more serious may occur to drugs used during surgery and prescription medicines. Allergic reactions may require additional treatment.

**Eyelash hair loss-** Hair loss may occur in the lower eyelash area where the skin was elevated during surgery. The occurrence of this is not predictable. Hair loss may be temporary or permanent.

**Delayed healing-** Wound disruption or delayed wound healing is possible.

**Long term effects-** Subsequent alterations in eyelid appearance may occur as the result of aging, weight loss or gain, sun exposure, or other circumstances not related to eyelid surgery. Blepharoplasty surgery does not arrest the aging process or produce permanent tightening of the eyelid region. Future surgery or other treatments may be necessary to maintain the results of a blepharoplasty.

**Surgical anesthesia-** Both local and general anesthesia involve risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia or sedation.

## **HEALTH INSURANCE**

If hooding of the upper eyelids interfere with your vision, your health insurance company may cover blepharoplasty surgery for the upper-eyelids only. Most health insurance companies exclude coverage for cosmetic surgical operations such as the lower-eyelid blepharoplasty or any complications that might occur from surgery. Please carefully review your health insurance subscriber information pamphlet.

## Risks of Blepharoplasty Surgery, continued

### ADDITIONAL SURGERY NECESSARY

There are many variable conditions in addition to risk and potential surgical complications that may influence the long term result of eyelid surgery. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with blepharoplasty surgery. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained.

### FINANCIAL RESPONSIBILITIES

The cost of surgery involves several charges for the services provided. The total includes fees charged by your doctor, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revisionary surgery would also be your responsibility.

### DISCLAIMER

Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your plastic surgeon may provide you with additional or different information which is based on all the facts in your particular case and the state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent on the next page.

# CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

1. I hereby authorize Dr. \_\_\_\_\_ and such assistants as may be selected to perform the following procedure or treatment:

I have received the following information sheet:

## INFORMED-CONSENT for BLEPHAROPLASTY SURGERY

2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.
3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involves risk and the possibility of complications, injury, and sometimes death.
4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
5. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.
6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.
7. I consent to the disposal of any tissue, medical devices or body parts which may be removed.
8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.
9. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:  
a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN  
b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT  
c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION.

\_\_\_\_\_  
Patient or Person Authorized to Sign for Patient

Date \_\_\_\_\_

\_\_\_\_\_  
Witness

### Pre-operative Check List

Patient _____	Acct# _____	
Date _____	Surgery date _____	
		Initials
_____ Financial Policy/ Consent signed		_____
_____ Copy of Insurance card in chart		_____
_____ Consents signed		_____
_____ Orders / Scripts (Done and Signed)		_____
_____ Labs Done by _____		_____
_____ Mammo _____ / EKG _____		_____
_____ Patient consent to treatment		_____
_____ Mentor implant acknowledgement		_____
_____ Mentor consent for silicone implants		_____
_____ Pregnancy waiver / _____ peer review (disclosure)		_____
_____ Photos taken (check book if not sure)		_____
_____ Green Sheet (Read __, Gone over __, Signed __)		_____
_____ Must explain to all cosmetic patients: Surgical cost information (Given to patient) *If further surgery should be necessary, for any reason, the patient will be responsible for the cost of the facility and anesthesia. Approximately \$2200.		_____
_____ Post operative instructions given to hospital patients		_____
_____ Sized Garment, Size _____		_____
_____ Weight _____ lbs. For all liposuction, abdominoplasty, and breast reduction patients		_____
_____ Must Order Breast , Chin, mandibular implants Size: _____ Catalog number _____		_____
_____ Reminder on all the following procedures: 1. Abdominoplasty 2. Thigh lifts 3. Inner thigh liposuction Patients need to shave pubic area the night before Surgery		_____
_____ Always mark orders for surgery as follows: "Patient not to be sedated until seen by Dr. Farahmand		_____

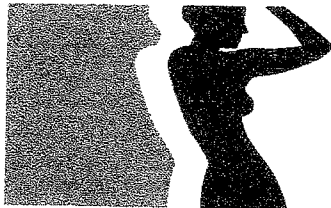


**FARAHMAND  
PLASTIC SURGERY**

**Pre-Operative Shopping List**

The following is a list of items that should be purchased prior to surgery in order to prepare for and more easily recover from surgery.

Have	Need
_____	<input checked="" type="checkbox"/> <b>Prescriptions</b> – have your prescriptions filled prior to surgery to save time on the way home when you won't be feeling up to stopping.
_____	<input checked="" type="checkbox"/> <b>Tylenol</b> or a generic form of this drug – this will be the drug of choice once you do not need the prescription strength pain medications.
_____	<b>Multivitamin</b> – to take prior to surgery and during your recovery for maximum health.
_____	Germ-inhibiting soap, such as <b>Dial</b> , <b>Safeguard</b> , or <b>Lever 2000</b> – to bath with prior to surgery in order to minimize germs.
_____	<input checked="" type="checkbox"/> <b>Straws</b> – you need to drink a lot of fluids after surgery in order to help get the anesthesia out of your body quicker and straws will help you drink more.
_____	<b>Frozen Peas</b> – these are great as “ice packs” for facial areas. Get 2-4 packages so that you can use 1 or 2 and have the others freezing.
_____	<input checked="" type="checkbox"/> <b>4 X 4 gauze and paper tape</b>
_____	<input checked="" type="checkbox"/> <b>Q-tips</b>
_____	<b>Hydrogen Peroxide</b>
_____	<input checked="" type="checkbox"/> <b>Gentle foods</b> – to encourage eating and not upset the stomach initially.
_____	Clear Soda (not diet): Ginger Ale, 7-Up, Sprite
_____	Plain crackers, saltine not buttery
_____	Soups, water based not cream based
_____	Pudding / Applesauce
_____	Jello
_____	Toast
_____	<input checked="" type="checkbox"/> <b>Other</b> <u>Artificial Tears</u>
_____	<u>Gentleal PM eye drops</u>
_____	_____



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**Pregnancy Waiver for Surgical Procedure**

Patient \_\_\_\_\_ Acct# \_\_\_\_\_

To Whom it may concern:

I, \_\_\_\_\_, choose to waive a serum pregnancy  
Test.

I am positive I am not pregnant at this time.  
In the event that I should discover otherwise, I agree to take full  
responsibility.

Surgical Date: \_\_\_\_\_

\_\_\_\_\_  
Date

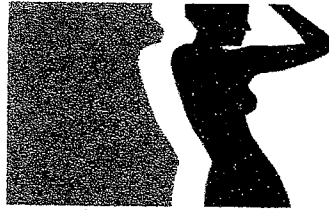
\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Audrey Farahmand MD • Plastic and Reconstructive Surgeon  
13710 Metropolis Avenue Unit #104 Fort Myers, FL 33912  
Phone (239) 332-2388 • Fax (239) 332-2382  
[www.farahmandplasticsurgery.com](http://www.farahmandplasticsurgery.com)





**FARAHMAND  
PLASTIC SURGERY**

**Audrey Farahmand MD**

**SURGICAL COST INFORMATION**

**OUR GOAL IS TO GIVE EACH AND EVERY PATIENT THE BEST RESULTS. UNFORTUNATELY APPROXIMATELY 5% OF ALL PLASTIC SURGERY PROCEDURES WILL REQUIRE REVISION(S) DUE TO EXCESS SCAR TISSUE.**

**SHOULD THIS HAPPEN, OUR POLICY IS TO ONLY CHARGE FOR FACILITY COSTS AND ANESTHESIA. THE CHARGE WILL BE APPROXIMATELY \$2200.00. YOU WILL NOT BE CHARGED FOR THE DOCTOR'S TIME.**

**THIS REVISION POLICY ABOVE IS APPLICABLE TO SCAR TISSUE ONLY FOR OUR BREAST AUGMENTATIONS. NOT INCULDED ARE DEFLATIONS OR CHANGING THE SIZE OF IMPLANTS.**

\_\_\_\_\_  
**PATIENTS SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**WITNESS SIGNATURE**

**Farahmand Plastic Surgery**  
**Authorization for Disclosure of Protected Health Information**  
**Medical Records Release**

Patient Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ (If applicable)

**I hereby authorize the release of my protected health information from:**

**(FROM)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**My protected health information is to be released to:**

**(TO)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

For the purpose of: **(Choose one)** \_\_\_\_\_ Continued Medical Care \_\_\_\_\_ Personal \_\_\_\_\_ Insurance  
Other: \_\_\_\_\_

The following information may be disclosed **(Choose one of the following)**:

\_\_\_\_\_ \*\*\*All Medical Records Covering dates \_\_\_\_\_ through \_\_\_\_\_

\_\_\_\_\_ \*\*\*Entire Medical Record

\_\_\_\_\_ \*\*\*Specific Medical Records: \_\_\_\_\_

\_\_\_\_\_ \*\*\*Other (Specify): \_\_\_\_\_

**\*\*\*I understand that these records may include information relating to:**

\*Acquired immunodeficiency syndrome (AIDS) / human immunodeficiency virus (HIV); or

\*Sexually Transmitted Diseases; or

\*Treatment for alcohol and/or drug abuse; or

\*Behavioral health service / psychiatric care

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. The revocation must be made by completing Farahmand Plastic Surgery's "Revocation of an Authorization to Release Protected Health Information" form. I also understand that I will not be denied or refused treatment if I refuse to sign this authorization. I further understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal and State privacy laws. I also understand that I have a right to receive a copy of this authorization if I request one. This authorization will expire "1" year from the date signed.

\_\_\_\_\_  
Signature of the Patient/Guardian/Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
(If not signed by patient) Print Name

\_\_\_\_\_  
Relationship to Patient



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Suite #104  
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**PATIENT NAME:** \_\_\_\_\_

**DATE OF SURGERY:** \_\_\_\_\_

**PROCEDURE:** \_\_\_\_\_

**TIME IN:** \_\_\_\_\_

**ANESTHESIA START:** \_\_\_\_\_

**SURGERY START:** \_\_\_\_\_

**SURGERY END:** \_\_\_\_\_

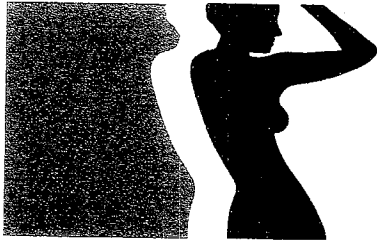
**ANESTHESIA END:** \_\_\_\_\_

**BLOOD LOSS:** \_\_\_\_\_

\_\_\_\_\_  
**SURGEON SIGNATURE**

\_\_\_\_\_  
**CIRCULATING NURSE**

\_\_\_\_\_  
**ANESTHETIST**



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## **Illicit/Illegal Drugs and Surgery Warning**

**WARNING:** If you have used or are planning to use illicit/illegal drugs within 72 hours of your surgical procedure, it could severely interfere with your anesthesia. It could cause a wide range of medical and surgical complications. The drug using patient having surgery needs special attention in order to avoid interactions and complications. Please speak to Dr. Farahmand about your drug use so that she may review the different drugs and their clinical effects and the problems which could be encountered.

If you have used illicit/illegal drugs 72 hours prior to your surgery it is recommended that you reschedule your surgery to another date.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date