Dermatology Care of Charlotte

www.dermcarecharlotte.com

(704) 341-0090 (Ballantyne) (704) 821-0615 (Indian Trail)

PREPARING FOR SURGERY

Your surgery will be performed under local anesthesia. We suggest that you eat a normal breakfast or lunch, unless otherwise specified. Please bathe or shower to minimize your risk of a surgical site infection. It is recommended you do not plan to participate in strenuous activities for 7-10 days following surgery.

Many patients are on blood thinning medications that are prescribed by their physicians. We do not recommend stopping them without explicit permission from the prescribing physician. Please stop taking any elective aspirin or anti-inflammatory medicines (like ibuprofen, Advil, Motrin, Naprosyn, Anacin and Bufferin), alcohol, vitamin E, ginko biloba and garlic pills at least one week before your surgery. They can increase your risk of bleeding during surgery. If your physician recommends aspirin please do not discontinue without permission.

Please fill out the pre-op questionnaire and consent form on the following page and bring with you to your surgical appointment. Please don't hesitate to call us for any other questions you may have about your upcoming surgery. Visit our website www.dermcarecharlotte.com for more information about skin cancer and our surgical services.

PRE OP QUESTIONNAIRE

Please check all relevant conditions:

_____Artificial heart valve	_____Keloids, thick scars	_____Artificial joints
_____Mitral valve prolapse	_____Heart murmur	_____Problems with local anesthesia
_____Pacemaker	_____Defibrillator	_____Previous/current Accutane
_____Hepatitis	_____HIV/AIDS	_____Implanted cochlear device
_____Pregnant	_____Immunosuppressed	_____Smoke
_____Drink alcohol	_____Bleed easily	_____Vagal nerve stimulator

_____Coumadin(warfarin), Plavix, Aspirin products, ibuprofen or arthritis medications
_____Blood thinning medication, including vit E, gingko biloba or herbal products
_____Problems with previous surgeries or dental work

Please list all medications you are taking:
_____

Do you have any medication allergies? _____ Yes _____ No
If yes, please
list:_____
Do you have allergy to: _____ tape _____ antibiotic creams _____ anesthetic_____ soaps/cleansers

_____ latex _____ Betadine/Iodine Do you take pre-op antibiotics?_____ Yes _____ No

SURGICAL CONSENT FORM

I hereby authorize Dr. Seward/Dr. Grattan/Dr. LaRocque to perform the following procedures:

_____.

I have been fully informed of the nature, purpose, possible alternative methods of treatment and that risk and complications include: bleeding, scarring, infection, abnormal sensation, discoloration and recurrence of tumor. No guarantee has been made regarding results that may be obtained.

I have been informed that a separate pathology fee will be charged for examination of any removed tissue.

I understand that portions of the procedure may be photographed and I consent to this as long as my identity is not revealed. I understand that these photographs may be used for medical documentation, teaching, research or scientific publication.

I have had the procedure and all that is involved explained to me. My questions have been answered to my satisfaction. I wish to proceed.

Patient/ guardian signature: _____ Date:_____

Witness signature: _____Date:_____

Physician signature:_____Date:_____