REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR CHEMICAL FACE PEEL

Patient's Name:_____ **Date**_____

PLEASE CHECK EACH BOX AFTER READING. If you have any questions please ask your doctor.

- ❑ I have been informed that I have the following conditions(s)_____
- ❑ These procedure(s) to treat my condition(s) has/have been described as:_____
  _____
- ❑ Chemical face peel is a process by which certain chemicals are applied to the skin of the face in an attempt to improve the appearance of lines, wrinkles, skin blemishes and certain other localized cosmetic skin conditions. Chemical face peel will neither stop the aging process nor totally eliminate wrinkles. The final result of treatment may not be apparent for several months. Future treatment may be necessary, depending upon the success of this initial treatment.
- ❑ During the face peeling process I will experience some discomfort and swelling, and my face will be covered with a crust which will usually separate within one to two weeks.
- ❑ My skin may have a reddish appearance which may persist for several weeks or longer, and at the junction of treated and untreated areas there may be a different color or blotching of the pigmentation and changed texture of the skin may persist.
- ❑ Scarring can occur which may result in permanent disfigurement.
- ❑ Chemical face peel will not stop the aging process, and further treatment may be necessary, depending upon aesthetic and cosmetic conditions.
- ❑ Other:_____
- ❑ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there is a risk of failure or relapse, my condition may worsen, and selective re-treatment may be required in spite of the care provided.
- ❑ I have had an opportunity to discuss my past medical and social history, including drug and alcohol use, with my doctor and have provided full information. I recognize that withholding information may jeopardize the planned goals of surgery.
- ❑ I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that my lack of cooperation can result in a less-than-optimal result.
- ❑ If any unforeseen condition should arise during surgery that may call for additional or different treatment from that planned, I authorize my doctor to use surgical judgement to provide appropriate care.
- ❑ I consent to the taking of photographs, video or audio recordings and agree to be interviewed for medical, scientific, or education purposes. Filming or photographing an operation may include my face and may reveal my identity.
- ❑ I have reviewed / viewed pre-operative and post-operative instructions.

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

_____*(Initial)* I agree to avoid direct sunlight for two (2) months after treatment and to use sun block of at least SPF 30 for 6-12 months thereafter. I hereby state that I have stopped all tobacco use 6 weeks prior to the procedure, recognizing their negative effect on healing and will not restart the use of tobacco for at least 6 months. I will not drink more than 2 glasses of wine or other alcohol beverage per 24 hour period during the healing period.

_____ *(Initial)* I have started the antiviral and antibiotic medicines prescribed to me.

_____ *(Initial)* I have been using the Obagi regiment with tretinoin as directed for at least 6 weeks.

_____*(Initial)* **Please inform your doctor if you have used Accutane®, Isotretinoin or any other medications prescribed by your physician or dermatologist during the past year. It is also very important to advise your doctor if you have ever had cold sores or other blister lesions on your face.** I have not used accutane in 2 years.

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INFORMATION FOR FEMALE PATIENTS

_____ *(Initial)* I understand that I am not a candidate for laser surgery if I am pregnant, might be pregnant, or am nursing a child.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in, and any inapplicable paragraphs were stricken before I signed. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date