

PSI Surgery Center, LLC
9985 Dayton Lebanon Pike, Centerville, OH 45458
(937) 886-2980

Surgery Date: _____ **Surgery Time:** _____ **Arrival Time:** _____

Nurse Visit/Prepay Date: _____ **Appointment Time:** _____

Post-Op Date: _____ **Appointment Time:** _____

Preparing for Your Nurse Visit

Prior to your Nurse Visit, go to our Website www.daytonplasticsurgery.com and complete the following:

- 1) **Print off and read your consent(s)**. Initial at the bottom of each page, fill out smoking status, sleep apnea and blood clot risks, but wait to sign the last page in the presence of the nurse at your nurse visit as this needs to be witnessed. (Go to Menu > Patient Resources drop down arrow > Patient Forms > Surgery Consents).
 - a. **Patient must quit smoking, vaping or using nicotine products at least four weeks prior to surgery.**
- 2) **Review Pre Op instructions** (Go to Menu > Patient Resources drop down arrow > Patient Forms > Pre-surgery Forms)
- 3) **Review ALL Post Op instructions** (Go to Menu > Patient Resources drop down arrow > Patient Forms > Post-Operative Instructions)
- 4) **Watch ALL videos** (Go to Menu > Videos).
- 5) **Read Information on Patient Rights and Advance Directives** (Go to Menu > Patient Resources drop down arrow > Patient Forms)
- 6) **Arrive 15 minutes prior to your scheduled nurse visit** Upon arrival, check in with the receptionist. She will confirm that you have read all of your Surgery Consents.
 - a. **If you have not done so, your appointment may be cancelled due to time limit constraints with appointments following yours.**
 - b. **THIS IS VERY IMPORTANT AND COULD RESULT IN YOUR SURGERY BEING RESCHEDULED AS WELL.**

PLEASE BRING THIS FORM AND CONSENT(S) TO YOUR NURSE VISIT

The Following must be completed prior to your Nurse Visit:

Teaching videos:

_____ How to Care for Your JP Drain	_____ How to Wear a Bandeau	_____ Abdominal Binder
_____ How to Wear a Chin Strap	_____ Wound Care	_____ How to Care for Your Pain Pump
_____ How to Give a Lovenox Injection		

Post Op Instructions:

_____ Abdominal Surgery	_____ Breast Surgery	_____ Lovenox Instructions
_____ Blepharoplasty	_____ Drainage Record	_____ Minor Surgery
_____ Body/Buttock/Thigh Lift	_____ Facial Surgery	_____ MENTOR Warranty
_____ Brachioplasty	_____ Hand Surgery	_____ Nasal Surgery
_____ Breast Reconstruction	_____ How to Care for Your JP Drain	_____ Nipple Reconstruction
_____ Breast Recon (at Hospital)	_____ Laser Resurfacing	_____ Scopolamine Patch Instructions
_____ Breast Reduction	_____ Liposuction/Fat Grafting	

Surgery Consents:

- | | |
|--|--|
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Fat Transfer Buttock |
| <input type="checkbox"/> Augmentation with Larger Implant than recommended | <input type="checkbox"/> Fat Transfer Face |
| <input type="checkbox"/> Augmentation Mammoplasty Saline | <input type="checkbox"/> Fat Transfer Hand |
| <input type="checkbox"/> Augmentation Mammoplasty Silicone | <input type="checkbox"/> Fat Transfer Procedures |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Ganglion Cyst Surgery |
| <input type="checkbox"/> Body Lift | <input type="checkbox"/> Gynecomastia |
| <input type="checkbox"/> Brachioplasty | <input type="checkbox"/> Hepatitis and HIV Testing |
| <input type="checkbox"/> Breast Implant Removal | <input type="checkbox"/> Labiaplasty |
| <input type="checkbox"/> Breast Lift Mastopexy | <input type="checkbox"/> Laser Resurfacing |
| <input type="checkbox"/> Breast Reconstruction Latissimus Muscle Flap | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Breast Reconstruction with Tissue Expanders | <input type="checkbox"/> Medial Thigh Lift |
| <input type="checkbox"/> Breast Reconstruction with TRAM Abdominal Muscle Flap | <input type="checkbox"/> Mini Abdominoplasty |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Nasal Injury Repair |
| <input type="checkbox"/> Brow Lift Surgery | <input type="checkbox"/> Nipple Reconstruction |
| <input type="checkbox"/> Buttock Lift Surgery | <input type="checkbox"/> Otoplasty |
| <input type="checkbox"/> Capsulectomy with Breast Implant Replacement | <input type="checkbox"/> Panniculectomy |
| <input type="checkbox"/> Capsulotomy with Breast Implant Replacement | <input type="checkbox"/> Placement of Breast Implant Following
Breast Recon by Tissue Expansion |
| <input type="checkbox"/> Capsulotomy Saline Replace | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Capsulotomy Silicone | <input type="checkbox"/> Scar Revision Surgery |
| <input type="checkbox"/> Carpal Tunnel Release Surgery | <input type="checkbox"/> Septoplasty |
| <input type="checkbox"/> Chemical Skin Peels and Treatments | <input type="checkbox"/> Skin Cancer Reconstruction |
| <input type="checkbox"/> Cutaneous Skin Flap Surgery | <input type="checkbox"/> Skin Cancer Surgery |
| <input type="checkbox"/> Extensor Tendon Repair Surgery | <input type="checkbox"/> Skin Graft Surgery |
| <input type="checkbox"/> Facial Implant Surgery | <input type="checkbox"/> Skin Lesion Tumor |
| <input type="checkbox"/> Facelift Surgery | <input type="checkbox"/> Tenolysis Surgery |
| <input type="checkbox"/> Flexor Tendon Repair Surgery | <input type="checkbox"/> Tip Rhinoplasty |
| <input type="checkbox"/> Fat Transfer Breast | <input type="checkbox"/> Trigger Finger |

_____(Initials) IN THE EVENT AT THE TIME OF DISCHARGE I DO NOT HAVE A RESPONSIBLE ADULT TO TAKE ME HOME & STAY WITH ME, I CONSENT TO TRANSPORTATION BY AMBULANCE & ADMISSION TO KETTERING MEDICAL CENTER. I UNDERSTAND THAT THIS WILL BE AT MY OWN EXPENSE.

I HAVE READ THE CONSENTS, INSTRUCTIONS, ADVANCED DIRECTIVES POLICY, INFORMATION ON PATIENT RIGHTS AND WATCHED THE VIDEOS THAT PERTAIN TO MY PROCEDURE.

_____/_____/_____
Signature of Patient (or Person Authorized to Sign for the Patient) Printed name Date

_____/_____/_____
Witness Printed name Date