Post-Operative Care Sheet for Y LIFT and Filler Injections

- Swelling and tenderness are NORMAL post effects of the procedure and will begin to subside after 48 hours. For some patients, it may take up to 2 weeks for everything to settle in. Again, all normal effects.
    - Most patients do not take any pain medication, but if you do experience discomfort, you may take Tylenol (acetaminophen). DO NOT TAKE IBUPROFEN, such as Advil, Motrin, as that may increase chances of developing bruising.
    - Bruising is very unlikely, but if a bruise develops, we recommend taking homeopathic ARNICA MONTANA pellets to speed healing (available at most health care stores, such as Whole Foods).
    - For swelling and fluid retention, DANDELION ROOT supplement/teas aids in flushing out excess fluid from the body as it is a natural diuretic (available at most health care stores, such as Whole Foods).
        - *Please check with Dr. Trokel if you are able to take Dandelion Root based on patients' medical condition(s) and/or medication counter indications.*
    - Post lower face treatment (jawline), maintain a soft chew diet for 24-48 hours such as soups, oatmeal, smoothies, yogurts, fish, etc.

- TO AVOID INFECTION of the injection sites, DO NOT WASH/WET the face for 24 hours. The injection sites close on their own after 24 hours.
    - **Please apply the antibiotic bacitracin ointment provided every 4 hours for 24 hours post treatment.**
    - NO makeup, SPF lotions, creams for 24 hours post treatment. Lipstick and eye makeup is OK.
    - You may shower after 24 hours post procedure.
    - If traveling on a plane or public transportation, use antibiotic ointment and cover the injection sites with Band-Aids.

- Sleep on your back for two days for everything to settle in.
- No exercise for 48 hours post treatment.
- Do not rest the face on hands, lean or put any pressure on the face.
- Do not massage the face, unless instructed by Dr. Yan Trokel.
- Patient is strongly advised to come in for a follow-up massage the next day.
- NO Facials/Lasers, or any other treatment that may cause pressure on the face for 2 weeks post procedure.

YLIFT

SOAP CHART

Patient Name: _____ DOB: _____

Date: _____/_____/_____
mm dd yyyy

Cosmetic History (NS) PMH PSH Allergies Meds

S: _____

_____

_____

_____

O: P.E. : NC/AT PERRL | EOMI | Forehead: vertical – horizontal Rhytids | Crows feet | Front laxity | Brow ptosis (R > < = L) Temple Atrophy | Supraorbital hollowing | Upper eyelid laxity – fat herniation | Lacrimal gland prolapse | Infraorbital hollowing (M/L) R / (M/L) L | Lower eyelid rhytids - laxity – fat herniation | Malar atrophy and descent | Buccal Atrophy | Prearicular fat loss | NFL (mild moderate severe) | Marionette lines (mild moderate severe) | Mandibular angle loss | Jowls | Prejowl sulcus | Chin - Mentalis strain/dimpling (large normal small) | Neck laxity | Submandibular gland descent / hypertrophy | Submental lipomatosis | Platysmal bands (medial / lateral) | Horizontal neck bands | Skin: Fitzpatrick (I II III IV V VI) | Facial rhytids (mild moderate severe) | Dischromias/Sun spots (mild moderate severe) | Telangiectasias (mild moderate severe) (red / blue)| Skin lesions (mild moderate severe)

A: _____

_____

_____

_____

P: _____

_____

_____

_____

Initials: _____

YLIFT

I, Patient: _____ DOB: _____ Date: _____
give my consent to **[INSERT PRACTICE NAME HERE]** to perform the following procedure:

Facial Injections Using Dermal Fillers

As previously and herein explained to me, other procedures deemed necessary or advisable may be necessary to complete the planned procedure.

After reading each paragraph, please initial to the left of the number as indicated.
If you have any questions, please ask your doctor before initialing the paragraph.

I hereby acknowledge that the following has been explained to me and I have had an opportunity to ask questions.

_____ Facial Injections are an aesthetic procedure to improve or reduce appearance of aging such as wrinkles, sagging of the skin on the face and loss of facial volume. Although generally Facial Injections will provide a person with a more youthful appearance, it is impossible to predict the exact result. The degree of improvement will be determined by age, heredity, bone structure and various individual characteristics of the skin and personal habits such as alcohol intake, nutrition and smoking.

_____ Facial Injections will not remove the small wrinkles around the eyes and lips, remove any discolorations around the eyes or remove skin blotches.

_____ I understand and agree that I have been completely candid and honest with **[INSERT PRACTICE NAME HERE]** regarding my motivation for undergoing Facial Injections. A "new" face does not guarantee an improved life.

_____ Smoking can affect the longevity and overall result of the procedure.

_____ Additionally, I have been advised and understand that Facial Injection procedures will not cease the aging process. Future and additional Facial Injection procedures may be necessary depending upon aesthetic and cosmetic considerations. Individual patient differences and expectations create wide differences in the results that can be anticipated.

_____ I understand to maintain results I will need to undergo touch up procedures, and additional fees are associated with such procedures.

Procedure Considerations

_____ Facial Injections is performed under local anesthetic.

_____ The procedure is generally performed first on one side of the face and then the other. Incision/needle size hole placement is determined by the judgment of **[INSERT PRACTICE NAME HERE]** before and at the time of the procedure. In many cases, the incisions are started up by the hairlines at the ear, and in the middle of the jawline and chin on each side.

_____ **[INSERT PRACTICE NAME HERE]** will then separate skin underlying fat and muscle from bone. The dermal filler will then be placed along the bone, in the muscle and under the skin to reshape and re-contour the aging face.

_____ Every reasonable attempt will be made to place incisions along the natural skin lines and creases. In rare cases scarring may result. In most cases, the scar will fade or become less visible as healing occurs. However, in some cases, the scars may be permanent; and in rare cases, a second procedure (scar revision) may be necessary.

Post-operative Considerations

_____ Post-operative pain/discomfort is rare, but can be controlled with medication. I understand that I will be asked to sleep on my back, and refrain from heavy activity for a few days to allow the product to settle properly.

_____ Post-operatively, swelling or bruising of the skin is uncommon but can generally last up to two weeks. The duration and intensity varies with each individual. Healing is a gradual process and the final results may not be realized for two to three weeks.

_____ Post-operatively, I understand I must avoid excessive or strenuous exercise such as aerobics, heavy lifting and housework for two weeks.

YLIFT

Risks and Complications

[INSERT PRACTICE NAME HERE] has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that this specific instance such operative risks include, but are not limited to:

- Delayed healing. In rare cases, necrosis (death of the skin) can occur. This may require additional treatment and surgical procedures.
- Infection and localized collection of blood are uncommon. Where necessary, antibiotics will be prescribed. In rare cases, serious infections may result in the need for additional treatment and/or hospitalization. Minor blood clots will be drained with a needle.
- Poor healing may result in excessive and permanent scarring, necessitating a second operation or scar revision.
- Blood loss is usually minimal; however, in some cases, a transfusion may be necessary. I have been explained my rights regarding autologous blood (self and family donation of blood).
- The procedure will involve areas of certain cranial or facial nerves. Damage to the nerves can result in numbness, usually temporary. However, in rare cases, the numbness can be permanent. Additionally, there is a risk to nerves that affect motor function. For example, there may be an inability to raise the eyebrows or move the lips. The condition is usually temporary; however, in rare cases, it **can be permanent**.
- As a result of scarring and swelling, there may be localized lumps or bumps- granulomas, which may require further surgical revision.
- Pain can be temporary or long lasting for the duration of the dermal filler, and can exacerbate preexisting pain syndromes.

Anesthesia

- I understand that certain anesthetic risks, which could involve serious bodily injury and death, are inherent in any procedure which requires anesthetic.
- I consent to the administration of such local, anesthesia as deemed necessary by **[INSERT PRACTICE NAME HERE]** who accomplish the proposed procedure.
- Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices or work, while taking such medications and/or drugs, or fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device at least twenty-four hours after my release from the procedure or until further recovered from the effects of the anesthetic medication and drugs that may have been given in the office or hospital for my care. I agree not to drive myself home and will have a responsible adult drive me or accompany me home after my discharge from the procedure. **FAILURE TO FOLLOW THIS INSTRUCTION MAY BE LIFE THREATENING!**
- If any unforeseen condition should arise in the procedure of the operation calling for **[INSERT PRACTICE NAME HERE]** judgment or for procedures in addition to or different from those now contemplated, I request and authorize **[INSERT PRACTICE NAME HERE]** to provide the appropriate service.

No Guarantee of Treatment Results

- 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 may be a risk of failure, my condition may worsen, selective re-treatment or worsening of my present condition despite the care provided.
- I have had an opportunity to discuss with **[INSERT PRACTICE NAME HERE]** my past medical and health history including any serious problems and/or injuries and have fully informed him of the same.
- I agree to cooperate fully with the recommendations of **[INSERT PRACTICE NAME HERE]** while I am under their care, realizing that any lack of the same can result in a less than optimal result or may be life threatening.
- I agree that this is a corrective procedure, and I release **[INSERT DOCTOR NAME HERE]** and **[INSERT PRACTICE NAME HERE]** of all claims and charges relating to this and/or any other procedure.

Female Patients

- I have advised **[INSERT PRACTICE NAME HERE]** as to whether or not I am currently utilizing birth control pills. I have been advised and informed that certain antibiotics and some pain medications may neutralize the therapeutic effect of birth control pills allowing for conception and resulting in pregnancy. I agree to consult with my family physician to initiate additional forms of mechanical birth control during the period of my treatment with **[INSERT PRACTICE NAME HERE]** and until I am advised that I can return to exclusive use of birth control pills by **[INSERT PRACTICE NAME HERE]**.

YLIFT

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO FULLY READ THE ABOVE CONSENT FORM AND UNDERSTAND THE TERMS AND WORDS WITHIN, AND THE EXPLANATIONS REFERRED TO. ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND NON-APPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN OUT BEFORE I SIGNED. I ALSO STATE THAT I SPEAK, READ AND WRITE ENGLISH.

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

Witness' Signature Date

Doctor's Signature Date

YLIFT

Authorization for Release and/or Publication of Photographs

I, _____, DOB: _____ hereby:
Print Full Name

☐ **AUTHORIZE** the release and/or publication of photographs that may be taken pre-operatively, during my surgery/procedure or post-operatively, without limitation regarding my physical and mental condition. I authorize the use of my photographs to be used in the following: (check all that applies)

- ☐ for use on website
- ☐ for use on social media (Facebook, Twitter, Instagram, etc.)
- ☐ for use in *patient before and after book*
- ☐ for teaching purposes

☐ **DO NOT AUTHORIZE** the release and/or publication of photographs that may be taken pre-operatively, during my surgery/procedure or post-operatively, without limitation regarding my physical and mental condition.

_____
Patient's (or Legal Guardian's) Signature — Date

_____
Witness' Signature — Date

YLIFT

Name: _____ DOB: _____ Date: _____

I acknowledge that I have received the products as written below during the course of my treatment today. I understand that the cost of treatment is based upon the quantity of products used and I take full responsibility to pay for the total cost as it has been explained to me.

Amount of Syringes	**QUANTITY**	**INITIALS**
Juvéderm Ultra XC 1.0mL	Syringes	
Juvéderm Ultra Plus XC 1.0mL	Syringes	
Juvéderm Voluma XC 1.0mL	Syringes	
Juvéderm Volbella XC 0.5mL	Syringes	
Botox/Xeomin/Dysport	Units	
Diazepam	Mg	
Valacyclovir	Mg	
Amoxicillin	Mg	
Clindamycin	Mg	
Other		
Other		

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

Witness' Signature Date

YLIFT

PATIENT PRODUCT PLACEMENT

Name:_____ **DOB:** _____ **Date:**_____

Product

Placement	**Right**	**Left**
Forehead		
Temple		
Glabella		
Supraorbital Rim		
Infraorbital Rim		
Malar/Cheek		
Prearicular		
Buccal		
Nasal Labial Fold		
Marionette Line		
Nose		
Lip		
Mandibular Angle		
Mandibular Body		
Chin		
Neck		

Total Syringes Used

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

YLIFT

PRE-PROCEDURE FEE ARRANGMENT AGREEMENT

Patient Name: _____ **DOB:** _____

Date: _____

PROCEDURE ESTIMATES	COST
1. Y LIFT with **Juvederm**	1.
2. Y LIFT with **Voluma**	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

I fully understand that the number of syringes required for my procedure as described by [INSERT PRACTICE NAME HERE] represents an ESTIMATED number of syringes and or units of product required for my procedure. I also fully understand that the ACTUAL number of syringes/units needed during the procedure may vary (fewer or greater in number) to obtain my optimal result. I understand that such variation may result in an increased cost of my procedure.

I certify that the above fee arrangement(s) for above said services have been fully explained to me and that I agree to provide payment in full.

_____

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

_____

Witness' Signature Date

_____

Doctor's Signature Date