Sean Mogan MD
Ocusight Eye Care Center

Laser Skin Resurfacing: *Pre-operative Instructions*

1. Before we start, please review the consent form thoroughly and make sure all your questions are answered.

2. Important Dates:

Day	Mon / /	Tues / /	Wed / /	Thurs / /	Fri / /
Procedure Scheduled					
Start Valtrex					
Start Antibiotic					

3. You will be here for approximately 2 hours. Please arrange for someone to pick you up at the end of the treatment. **You will not be allowed to drive home.**

4. **Valtrex & Antibiotic:** *Take as directed prior to treatment, and continue until you finish all tablets*. If you have a reaction, call us immediately. Please call if you develop a cold sore prior to your treatment date.

5. We will offer to call a prescription in for pain control and anti-anxiety medications for the day of treatment. We ask that you **bring these medications with you** the day of the procedure.

6. You need to stop taking Aspirin or other pain medication such as Motrin, Celebrex, Aleve, and Ibuprofen, 10 days before the procedure; that is, ____________. You may take Tylenol (acetaminophen) for pain.

7. Supra-therapeutic dose of Vitamin E and other herbal supplements have been associated with increased bleeding risk. Please let us know if you are on any herbal supplements.

8. On the day of treatment, please come to the office with no make up and a lower-cut, buttoned shirt. Do not wear contact lenses for that day.

9. **Please have following items ready before your treatment day**:
• Hairbands and ties to keep hair off your face and neck: make sure they are soft and not too tight, as you may need to keep them on for 48 hours.
• Home environment: make sure that you have a room is free from direct sunlight. Blinds and drapes are sufficient. Vacuum the room and laundry linens to cut down risk of infection.
• Sunblocks with SPF 30 or above: once the skin is healed, you will be instructed to apply sunscreen liberally for 3 months.
• Arrange for backup help during the week after the procedure in case you need help.

By signing below, I acknowledge that I have read and understood the information written above, and a copy was given to me. I agree to follow all above instructions.

______________________________ ______________________________
Patient or Guardian Signature Date Witness Signature Date

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Dr. Sean Mogan Date