HIGHPOINT
plastic surgery

Laser Treatment – Pre & Post-Treatment Information

Before Your Treatment:

- Use a sun block with an SPF of at least 30 every day
- Do not use any exfoliants, facial scrubs, retina-A, Renova or any other harsh or photo or light sensitive products for 2 weeks prior to your treatment
- Do not get any facials, chemical peels, electrolysis, waxing, or tweezing for 2 weeks prior to your treatments
- If prescribed, begin antiviral regimen 48 hours prior to treatment
- Discontinue use of Aspirin, Plavix, Cumadin, or any other blood thinner or aspirin containing over-the-counter medications one week prior to treatment. If aspirin has been prescribed by either your PCP or cardiologist, please let us know and we will determine whether you should discontinue use.
- Please let us know if you have anxiety or request an anti-anxiety medication prior to treatment. In the event that this is prescribed you will need someone to drive you home following your treatment

Shopping List:

- Cetaphil Cleanser
- 4” x 4” gauze pads
- Tylenol®
- Aquaphor
- Sun block
- Hydrocortisone 1%
- Prescriptions

Day of Procedure:

- Please dress in comfortable clothes
- Do not wear makeup or jewelry
- Please arrive one hour prior to your scheduled laser treatment

Post-Treatment Instructions

- Avoid sunlight for at least one week following your treatment
- Gently cleanse the treated area three times per day using 4” x 4” gauze pads and Cetaphil Cleanser
- Pat dry and then apply a thin layer of Aquaphor ointment
- Your skin may feel hot and tight. There may be areas where bleeding has occurred during treatment. This is normal
- Do not pick or try to peel the treated area. Let your skin exfoliate naturally. Apply sunscreen when leaving home
- If you experience any itching or irritation, apply hydrocortisone 1% to the affected area
- Take Tylenol for pain if you are not on prescription medication
- Drink plenty of fluids
- Relax. Let yourself heal

Call the Office at (561) 406-6574 if you have any fever, excessive swelling or bleeding

Date _____ Time _____ AM/PM X_____

Signature (Patient/Health Care Agent/Guardian/Family Member) (If patient’s consent cannot be obtained, indicate reason above.)