STOP READ

IMPORTANT INFORMATION AND CONSENTS

This is a surgeons office, the following is important if surgery is recommended. This may not apply to all patients. You will receive a copy of this.

Pre-operative instructions:

- Do not eat or drink anything after midnight the night before your surgery
- **No aspirin or aspirin-related products at least one (1) week prior to your surgery**; Tylenol is OK
- Notify the nurse of any medication changes

FMLA/Short Term Disability:

Please be aware that we provide this service in an effort to assist out patients with a necessary completion of forms for leave from work following surgery. The completion of these forms will be executed by our staff as time permits and the following fee will be charged: **$35.00.** The fee must be paid before the form can be sent to your employer or disability carrier.

- Turnaround time is 7-10 day once payment is received/Paperwork will **not** be completed while you wait.
- Our office will only approve short term leave at time of surgery. This mean we are unable to write for intermittent leave or long term disability. **Estimated time off after a lumpectomy is about 48 hours. Estimated time off after a mastectomy varies 2-6 weeks depending on reconstruction.**
- Should you be considering breast reconstruction, your plastic surgeon will be the one to complete these forms as he/she will be the one addressing limitations, restrictions, and when return to work will be.

By signing below you have read and understand the above concerning pre op instructions and FMLA.

Patient Signature: _____ Date: _____

Patient Photo Consent

I consent for medical photographs to be taken by Dr. Archana Ganaraj, Dr. Carolyn Thomas, and Dr. Walter Lee Bourland or a representive. We do not do this with every patient. These photos will only be used for your medical record, conferences and journals here in the office. These photographs will have no indentifing information such as your name or your face. Refusal to consent to the photographs will in no way effect your medical care you receive. If you wish to withdraw your consent in the future you may do so with written consent.

By signing below you are giving consent.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date : _____