YARROW BAY
PLASTIC SURGERY

SMOKING/NICOTINE POLICY ACKNOWLEDGMENT

Patient Name: _____ DOB: _____

___ I am a non-smoker and have never used nicotine or tobacco products.

___ I am a former smoker; I quit _____ months ago/ I quit _____ years ago.

___ I am a smoker; I smoke _____ cigarettes/_____ packs per day.

Today's Date: _____

I have been advised by Dr. McMillan/Dr. Liebertz and their staff that I must not smoke or use nicotine substitutes for a MINIMUM of six (6) weeks prior to my surgery and six (6) weeks post-op. I have also been advised that being in the presence of second-hand smoke can compromise my surgery and its outcome.

It has been explained to me that the risks of surgery are greater for smokers and even if I abstain from cigarette/nicotine product and/or substitute use for six (6) weeks before and after surgery, I still may experience the effects of nicotine.

There is a greater risk in smokers to experience bad scarring, hematoma formation, intraoperative bleeding, post-operative bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyperpigmentation.

I acknowledge that I have read and fully understand the above consent to operate, given my smoking status. I understand that the risks have been fully explained to me and I wish to proceed with surgery.

_____ _____

PATIENT SIGNATURE DATE