Medication Precautions for Liposuction

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These instructions are to be followed before and after your surgery. If you are on any anti-rheumatoid anti-arthritic, circulation or anticoagulant medication (Motrin, Naprosyn, Presantine or Coumadin), please inform us immediately.

1. For a two (2) week period prior to and after the scheduled procedure(s), please do not take any medications that contain aspirin or aspirin related products.

2. Do not take pain medications other than Tylenol for two (2) weeks prior to surgery.

3. Aspirin has an effect on your blood's ability to clot and could increase your tendency to bleed at the time of surgery and during the post-operative period.

4. Please check the labels of all medications that you take, even those available without a prescription to make sure you are not taking any aspirin or aspirin-like substances.

5. Please consult your physician before stopping any prescribed medications.

The following is a list of medications and substances that can increase your tendency to bleed:

Advil Alcohol Vitamin E Alka Seltzer Anacin Anaprox Anaproxin APC 5 ASA Ascodeen Ascriptin Aspirin Bufferin Cephalgesic Cheracol-Capsules Children's Aspirin Cinoril Congesprin Cope Coricidin Coumadin Darvon Darvon with ASA Dolobid Dristan Easprin Ecotrin Empirin Excedrin Feldene Fiorinal 4-Way Cold Tabs Ibuprofen Indomethanic Meclomen Medipren Midol Motrin Nalfon Naprosyn Nuprin Percodan Phenaphen Quagesic Robasisal Rufin Sine Off Sine Aid Trandate Rrental Trigesic Trilisate Vanquish Voltaren Zactrin Zorprin

If you need minor pain medication, please take acetaminophen (Tylenol) or another non-Aspirin medication. Tylenol or Anacin 3 are available at your local pharmacy without a prescription and have comparable pain relief to that of Aspirin. If you are allergic to Tylenol or are unable to take it for other reasons, please notify us so that we might arrange for a suitable substitute.

I have read the medication precautions for liposuction surgery and fully understand its contents.

_____ ____/____/_____

Patient's Signature Date

_____ ____/____/_____

C.F.B.B. Witness Date