Labiaplasty
Packet

- **Patient copies of post-op instructions are on top of the packet.**
- **If more than one page, staple them together and place one patient label on the first page only.**
- **No need to hole punch patient copies of post-op instructions. Just place instructions inside the chart.**

PELOSI MEDICAL CENTER

DVT PATIENT INFORMATION

What is Deep-Vein Thrombosis (DVT)?

DVT occurs when a blood clot forms in one of the large veins, usually in the lower limbs, leading to either partially or completely blocked circulation. The condition may result in health complications, such as a pulmonary embolism (PE) and even death if not diagnosed and treated effectively.

Most common risk factors for DVT:

- Major surgery
- Congestive heart failure or respiratory failure
- Restricted mobility
- Recent injury
- Cancer
- Obesity
- Age over 40 years
- Recent surgery
- Smoking
- Prior family history of venous thromboembolism (VTE)

Signs and Symptoms of DVT:

About half of people with DVT have no symptoms at all. For those who do have symptoms, the following are the most common and can occur in the affected part of the body, typically in the leg or calf region.

- Swelling unrelated to the surgical site,
- Pain or tenderness, unrelated to the surgical site and often worse when standing or walking,
- Redness of the skin,
- Warmth over the affected area.

What is Pulmonary Embolism (PE)?

A pulmonary embolism (PE) is a very serious condition that occurs when a blood clot blocks the artery that carries blood from the heart to the lungs (pulmonary artery). A clot that forms in one part of the body and travels in the bloodstream to another part of the body is called an embolus. PEs often come from the deep leg veins and travel to the lungs through blood circulation.

Signs and Symptoms of PE

- Difficulty breathing;
- Faster than normal heart beat;
- Chest pain or discomfort, which usually worsens with a deep breath or coughing;
- Coughing up blood; or
- Very low blood pressure, lightheadedness, or blacking out.

**** If you develop symptoms of a Pulmonary Embolism, seek emergency medical attention immediately. Dial 911 to be transported to the nearest Emergency Room.***

Patient Signature _____ Date _____

PELOSI MEDICAL CENTER

OFFICE SURGERY CHECKLIST

Procedure (Pt 1) _____ **Surgery Date/Time**: ____/____/____ _____ am/pm

Procedure (Pt 2) _____ **Surgery Date/Time**: ____/____/____ _____ am/pm

Surgeon ☐ MP2 ☐ MP3

#	Task	Date Completed	Initials	Comments
1	Consultation done	___/___/___	_____	_____
2	Signed copy Cosm. Surgery Finan. Agreement given to pt.	___/___/___	_____	_____
3	Blood work drawn. **Must be drawn within 7 days of date of surgery**	___/___/___	_____	**Panel**: CBC, Comp. Met. Panel, PT/PTT, HIV Screening, Hepatitis B & C Screening Repeat PT/PTT if lab panel results in chart. Repeat Panel if date of lab panel results in chart is not within 7 days of scheduled procedure. _____
4	Lab results reviewed by Dr. Pelosi.	___/___/___	_____	_____ _____
5	Medical Clearance Needed? ☐ YES ☐ NO	___/___/___	_____	_____ _____
6	Prescriptions given to patient.	___/___/___	_____	Pt instructions for all Rx's: **Do NOT take day of surgery**

__ Cephalexin	500 mg PO	BID x 8 days (#16)	Begin day before surgery
__ Doxycycline	100 mg PO	BID x 8 days (#16)	Begin day before surgery
__ Flexeril	10 mg PO	TID x 7 days (#21)	2 refills
__ Gabapentin	600 mg PO	TID x 10 days (#30)	
__ Naproxen	500 mg PO	BID x 15 days (#30)	
__ Zofran	8 mg PO	BID as needed (#10)	As needed for nausea

Physician Signature _____

7	Breast implants ordered Breast implants received	___/___/___ ___/___/___	_____ _____	_____ _____
8	Anesthesiologist scheduled	___/___/___	_____	_____
9	Surgery date scheduled & confirmed with patient	___/___/___	_____	_____ _____
10	COVID PCR test performed within 6 days of surgery	___/___/___	_____	
11	Pre-op call made to patient	___/___/___	_____	Med. Asst is responsible for calling patient the day before surgery to reinforce pre-op instructions & answer questions. **Instruct patient to be NPO 8 hrs prior to scheduled procedure time and to bring in a list of current meds and doses.** _____ Allergies: _____ LMP: ____/____/____
12	Lipo touch-ups: Pt advised to bring in old garment	___/___/___	_____	_____ _____
13	**Total Fee: $ _____** Deposit Pd: $ _____	___/___/___	_____	_____ _____
14	Balance Due: $_____ $_____ $_____	___/___/___ ___/___/___ ___/___/___	_____ _____ _____	_____ _____ _____

PELOSI MEDICAL CENTER

DVT PATIENT INFORMATION

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Signs and Symptoms of PE

- Difficulty breathing;
- Faster than normal heart beat;
- Chest pain or discomfort, which usually worsens with a deep breath or coughing;
- Coughing up blood; or
- Very low blood pressure, lightheadedness, or blacking out.

**** If you develop symptoms of a Pulmonary Embolism, seek emergency medical attention immediately. Dial 911 to be transported to the nearest Emergency Room.***

Patient Signature _____ Date _____

PELOSI MEDICAL CENTER

Medication Reconciliation/ Discharge Summary

Patient Address: _____

ALLERGIES/SENSITIVITIES (Drugs, Materials, Food, or Environmental Factors)	
☐ **No known allergies/sensitivities and other reactions to drugs, materials, food, or environmental factors**	
Allergen	**Reaction**

MEDICATIONS & SUPPLEMENTS						SURGEON to Indicate:		
Medication List: OTC, Herbals, Vitamins & Supplements		DOSE (Strength)	HOW TAKEN?	FREQUENCY (How often taken)	LAST TIME TAKEN	CONTINUE		
						YES	HOLD	NO
1								
2								
3								
4								
5								
6								

Medication History Verified by RN/MA: _____ Date: _____

If a medication is placed on hold or discontinued, Surgeon to indicate patient follow-up instructions below:

_____

_____

IN ADDITION TO THE PRESCRIPTIONS BELOW, THE ABOVE MEDICATIONS SHOULD BE CONTINUED AT HOME UNLESS SPECIFIED BY SURGEON TO HOLD OR DISCONTINUE AS CHECKED ABOVE	
SIGNATURE OF SURGEON REVIEWING MEDICATIONS: (REQUIRED)	DATE:

PRESCRIPTIONS GIVEN TO PATIENT AT DISCHARGE					
Mark with "x"	**Medication Name**	**Dose**	**Route**	**Frequency**	**Reason for Medication**
____	Cephalexin	500 mg	By mouth	2 times a day	Antibiotic
____	Cyclobenzaprine	10 mg	By mouth	3 times a day	As needed, for muscle pain
____	Doxycycline	100 mg	By mouth	2 times a day	Antibiotic
____	Gabapentin	600 mg	By mouth	3 times a day	As needed, for pain
____	Naproxen	500 mg	By mouth	2 times a day	As needed, for pain
____	Ondansetron	8 mg	By mouth	2 times a day	As needed, for nausea
____					

Procedure(s) Performed: _____

Medications administered during this visit: ☐ Ceftriaxone ☐ Cephalexin ☐ Clindamycin ☐ Diazepam ☐ Diphenhydramine ☐ Diprivan ☐ Doxycycline ☐ Epinephrine ☐ Fentanyl ☐ Glycopyrrolate ☐ Lidocaine ☐ Metoclopramide ☐ Midazolam ☐ Ondansetron ☐ Oxycodone ☐ Sodium Bicarbonate ☐ Tranexamic Acid ☐ Other _____

Information provided to: ☐ Patient _____ ☐ Other _____
(*patient signature*) (*name of person*)

Discharge Physician/RN Signature: _____ Date: _____ Time: _____

PELOSI MEDICAL CENTER

OFFICE SURGERY PRE-OP HISTORY & PHYSICAL EXAM

CHIEF CONCERN / REQUEST:

PERTINENT PAST MEDICAL & SURGICAL HISTORY AND REVIEW OF SYSTEMS:

PHYSICAL EXAMINATION:

Height _____ Weight _____ lbs Pre-op Exam Vital Signs: BP_____ T _____ HR _____ RESP _____

WNL	ABN		COMMENTS
D	D	General appearance	
D	D	Mental Status	
D	D	Neurological	
D	D	Cardiovascular	
D	D	Lungs	
D	D	Abdomen	
D	D	Genitourinary	
D	D	Liver	
D	D	Extremities	
D	D	Integument	
D	D	Other	

CURRENT MEDICATION	DOSAGE

CURRENT MEDICATION	DOSAGE

ALLERGIES/SENSITIVITIES			
☐ No known allergies/sensitivities and other reactions to drugs, materials, food, or environmental factors			
Allergen/Sensitivity	Type of Reaction	Allergen/Sensitivity	Type of Reaction

Adverse Reactions to Drugs: ☐ No ☐ Yes _____

PROVISIONAL DIAGNOSIS:

LETTER OF MEDICAL CLEARANCE NEEDED?___ YES ___ NO

PHYSICIAN SIGNATURE _____ **DATE** ____/____/____

Pelosi Medical Center

VTE RISK FACTOR ASSESSMENT

Date: ___/___/___

Age: _____ Wt (lbs): _____ BMI: _____

Sex: _____ Ht (in): _____

CHOOSE ALL THAT APPLY

Add **1 Point** for Each Risk Factor

___ Age 41-60 years
___ Minor surgery (< 45 min) planned
___ Past major surgery within last month
___ Visible varicose veins
___ History of inflammatory bowel disease
___ Swollen legs (current)
___ Overweight or obese (BMI > 30)
___ Serious infection (< 1 month)
___ Lung disease (e.g., emphysema, COPD)
___ Heart attack
___ Congestive heart failure
___ Other risk factors _____

Add **2 Points** for Each Risk Factor

___ Age 61-74 years
___ Planned major surgery (> 45 minutes)
___ Previous malignancy (excl skin cancer, but not melanoma)
___ Central venous access within last month
___ Non-removable plaster cast that kept pt from moving leg within last month
___ Confined to a bed for 72 hrs or more

Add **3 Points** for Each Risk Factor

___ Age 75 years or over
___ History of blood clots – either DVT or PE
___ Family history of blood clots (thrombosis)
___ Personal or family history of positive blood test indicating increased risk of blood clotting

For Women Only: Add **1 Point** for Each Risk Factor

___ Current use of oral contraceptives or hormone replacement therapy
___ Pregnancy or postpartum within last month
___ History of unexplained stillborn infant, recurrent spontaneous abortion (> 3), premature birth with toxemia or growth- restricted infant

Add **5 Points** Each Risk Factor that **applies now or within the past month**

___ Elective hip or knee joint replacement surgery
___ Broken hip, pelvis, or leg
___ Serious trauma e.g., multiple broken bones due to a fall or car accident
___ Spinal cord injury resulting in paralysis
___ Experienced a stroke

TOTAL RISK FACTOR SCORE _____

Score	Risk Level	Prophylaxis for Surgical Patients
0-2	Low	• Early ambulation
3-8	Increasing	• Apply antiembolism stockings and intermittent pneumatic compression device • Flex patient's knees to approximately 5° by placing a pillow underneath them • Stage multiple procedures • Provide patient with DTV Patient Information Sheet • Instruct patients who are taking oral contraceptives or hormone replacement therapy to discontinue taking these medications 1 week prior to surgery.
> 8	18.3%	• Not a candidate for office-based surgery

PELOSI MEDICAL CENTER

PHYSICIAN PERIOPERATIVE ORDERS

PRE-OPERATIVE

Enter 'x' next to medication & circle prescribing dose

☐ DiphenHYDRAMINE	**25** / **50** mg PO x 1	☐ CefTRIAXone	**1** gm (< 79 kg) **2** gm (≥ 79 kg) **3** gm (≥ 120 kg) IV Piggyback x 1
☐ Diazepam	**10** / **20** mg PO x 1	☐ Clindamycin	**600** mg (< 70 kg) **900** mg (≥ 70 kg) IV Piggyback x 1
☐ FentaNYL	**50** / **75** / **100** mcg IM x 1	☐ Cephalexin	**500** / **1000** mg PO x 1
☐ Midazolam	**2** / **4** / **6** / **8** mg IM x 1	☐ Doxycycline	**100** / **200** mg PO x 1
☐ OxyCODONE	**5/325** / **10/650** mg PO x 1		

___ Apply ECG, NIBP, & Pulse Oximeter monitors during procedure

___ Urine pregnancy test (n/a if female > 55 yrs old or if post-hysterectomy)

___ Apply Norm-o-temp heating pad. Set temperature to_____° F (no greater than 104° F)

Additional pre-operative orders: _____

_____

INTRA-OPERATIVE

___ Tumescent Anesthetic Solution - Use 1000ml bags of 0.9% NaCl

Bag #	Lidocaine (mg)	Epinephrine (mg)	Sodium Bicarbonate 8.4% (ml)	Tranexamic Acid (mg)
1			10	
2			10	
3			10	
4			10	
5			10	

Bag #	Lidocaine (mg)	Epinephrine (mg)	Sodium Bicarbonate 8.4% (ml)
6			10
7			10
8			10
9			10
10			10

___ Apply thromboembolic stockings and Intermittent Pneumatic Compression Device set at **40mm Hg**

Additional intra-operative orders: _____

_____

POST-OPERATIVE

___ Discontinue IV when discharge criteria are met

___ Remove Foley catheter

Additional post-operative orders:

_____

PHYSICIAN SIGNATURE_____ **DATE/TIME:** ____/____/____ ____:___

ADDITIONAL ORDERS:

_____

_____

_____

PHYSICIAN SIGNATURE_____ **DATE/TIME:** ____/____/____ ____:___

Pelosi Medical Center

LABIAPLASTY CONSENT

DATE: ____/____/____

1. I hereby authorize **Drs. Pelosi or their Designees** and/or such assistants as may be selected and supervised by them to treat the following condition(s):

   Enlarged (elongated), and/or asymmetric (uneven), and/or hyperpigmented (darkened) labia minora; enlarged and/or asymmetric skin at, or adjacent to, the prepuce (clitoral hood). Conditions may involve either or both labia minora.

2. The medical/surgical treatment proposed is:

   Excision of excess labia minora tissue and plastic reconstruction, and/or excision of excess clitoral hood and/or surrounding tissue and plastic reconstruction, and/or scar revision and plastic reconstruction of previously operated areas. Procedure may include laser surgery and/or radiofrequency surgery.

   (Lay terminology) *I have been told that this procedure may subject me to a variety of discomforts and risks. I understand that I will not be fully recovered from this surgery for approximately 4-6 weeks. Most patients have surgery with little difficulty, but problems can happen ranging from minor to fatal. These include nausea, vomiting, pain, bleeding, infection, poor healing, or formation of fistulas, adhesions or strictures. Urinary retention requiring catheter drainage may occur. Sexual function may improve following complete healing, but improvement cannot be guaranteed and worsened sexual function is a possibility. Unexpected reactions may occur from any drug or anesthetic given. Unintended injury may occur to other pelvic or perineal structures such as external and internal anal sphincters, and local nerves or blood vessels. Any such injury may require immediate or later additional surgery to correct the problem. Dangerous blood clots may form in the legs or lungs. Physical and sexual activity will be restricted in varying degree for an indeterminate period of time, but most often 3-6 weeks. Finally, I understand that it is impossible to list every possible undesirable effect and that the condition for which surgery is done is not always cured or significantly improved, and in rare cases may even be worse.*

3. The procedure has been explained in terms understandable to me, which explanation has included:

   a. The purpose and extent of the procedure to be performed;
   b. The risks involved in the proposed procedure, including those, which, even though unlikely to occur, involve serious consequences.
   c. The possible or likely results of the proposed procedure;
   d. The feasible alternative procedures and methods of treatment;
   e. The possible or likely results of such alternatives;
   f. The results likely if I remain untreated.

4. I am aware that there are other risks, such as loss of blood, infection or death that attend the performance of any surgical procedure. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee or assurances have been made to me concerning the results of the proposed treatment.

5. I have had sufficient opportunity to discuss my (the patient's) condition and treatment with the doctor and/or his associates, and all of my questions have been answered to my satisfaction. I believe that I have had adequate knowledge upon which to base an informed consent to the proposed treatment.

6. I consent to the performance of additional operations and procedures different from those contemplated and deemed necessary or advisable during the course of the authorized procedure because of unforeseen conditions. The authority under this paragraph shall extend to all conditions that require treatment but were not known to the named doctor, at the time the procedure commenced.

7. I impose no specific limitations or prohibitions regarding treatment other than those that follow: (If none, so state)
   _____.

8. I consent to the administration of anesthesia and/or conscious sedation as may be deemed advisable by, or under the direction and supervision of, the physician responsible for this service. The risks, alternatives, and benefits have been discussed.

9. I consent to the retention or disposal of any tissues or parts, which may be removed.

10. I consent to the taking of photographs and videotape of the operation, procedure and/or tissue for scientific, educational and documentation purposes.

Pelosi Medical Center

LABIAPLASTY CONSENT

11. I understand that technical consultants may be available and present in the OR at the request of the above named physician(s).

12. I understand that medical or nursing students may be present as observers.

13. I understand that the transfusion of blood, blood bank products or autologous blood may be a necessary part of my treatment – the risks, alternatives and benefits have been explained and I therefore give consent.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND, AND CONSENT TO THE ABOVE PROCEDURE(S), THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. THAT ALL BLANKS AND STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. Any stricken paragraph must be initialed by both the patient and the physician.

_____	___/___/___	_____	___/___/___	_____	__/___/___
Patient Signature	Date	Witness Signature	Date	Surgeon Signature	Date

Pelosi Medical Center

CIGARETTE SMOKING ATTESTATION

All procedures in cosmetic surgery are performed to improve form and, in some cases, function. Our goal as cosmetic surgeons is to achieve improvement with minimal scarring. Unfortunately, smoking and secondary smoke affect wound healing in a potentially devastating way. Please be honest with us about your exposure to smoke so we can take good care of you and prevent problems and complications with your procedure.

Any exposure to smoke either directly or indirectly can result in poor wound healing, delayed wound healing, skin loss requiring skin grafting, increased risk of wound infection, and loss of skin and deeper tissues, all due to decreased blood supply to those areas. The reduced blood flow to skin wound edges can cause skin to break down and scab. This will negatively affect the quality and nature of the scar (there is an increased risk of hypertrophic or keloid scarring). This is true for any surgical procedures requiring incisions (even skin lesion removal and liposuction).

The following is a partial list of cosmetic procedures and the impact that smoking or inhaling second-hand smoke may have on wound healing. It is not intended to be a complete list of procedures or all possible complications. Because of these potential complications, the immediate stopping of smoking at least 4 weeks before the surgeries and postoperative abstinence for life, or for at least 4-6 weeks postoperative, is advised.

Breast Implants (Reconstruction, Tissue Expanders, and Augmentation): There is an increased risk of delayed wound healing, capsular contracture, and implant infection with the possibility of extrusion.

Breast Reduction and Breast Lift (Mastopexy): There can be delayed wound healing resulting in unsightly scarring and skin loss and potential nipple loss requiring skin graft. In all cases of patients who smoke or are exposed to smoke, wounds do not heal in the normal length of time. Wound healing can be prolonged as long as 3-4 months.

Abdominoplasty: Smoking or exposure to smoke will decrease the ability of the skin to heal properly resulting in unsightly scarring, higher risk for infection, and skin loss sometimes requiring a skin graft. Slow wound healing (months instead of weeks), skin loss resulting in scabbing and prolonged need for dressing changes, and infection (usually requiring antibiotics and sometimes another surgery to drain the infection) are all complications that can occur if you smoke or are exposed to second-hand smoke. If you have either stopped smoking very recently or have been unable to stop completely, you must accept these risks if you wish to proceed with surgery.

Liposuction and Fat Transfer: There is an associated increased risk of skin complications with *liposuction* (postoperative pain, inflammation, infection, bruising, swelling, loss of sensation in the skin, skin irregularities, skin necrosis, fat embolism, seroma, scarring, changes in skin coloration, etc.) and *fat transfer* (infection, fat necrosis, skin irregularities, and decrease in the retention of injected fat, etc.) in smokers.

Patient Initials

_____ I have read and understand the Patient Information on Cigarette Smoking and Cosmetic Surgery and I have had all of my questions regarding this form answered to my full satisfaction by my surgeon prior to my operation today.

IF YOU HAVE NEVER SMOKED CIGARETTES:

_____ I attest that I have never smoked cigarettes.

IF YOU ARE A PREVIOUS OR CURRENT SMOKER:

_____ I attest that I (have/have not) _____ quit cigarette smoking or refrained from cigarette smoking for at least four (4) weeks prior to my surgery today.

_____ I have been advised by my surgeon to refrain from cigarette smoking for at least six (6) weeks after my surgery today and preferably to quit smoking permanently.

Print Name: _____ **Signature:** _____ **Date:** ____/____/____

PELOSI MEDICAL CENTER

ANESTHESIA CONSENT

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the anesthesia/analgesia.*

I voluntarily request that anesthesia care (analgesia) as indicated below be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or other practitioner, and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

I understand that anesthesia/analgesia involves additional risks and hazards but I request the use of anesthetics/analgesia for the relief and protection from pain during the planned and additional procedures. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis, or death.

I also understand that other complications may occur. Those complications include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial.

☐ _____ LOCAL ANESTHESIA/ANALGESIA and/or TUMESCENT ANESTHESIA - drowsiness, allergic reaction, nausea and vomiting, nervousness, apprehension, euphoria, confusion, dizziness, blurred or double vision, generalized muscle twitching, seizures, respiratory depression, bradycardia, peripheral vasodilation, hypotension, depressed myocardial contractility, depressed cardiac conduction.

☐ _____ REGIONAL BLOCK ANESTHESIA/ANALGESIA - nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.

☐ _____ MONITORED ANESTHESIA CARE (MAC) or SEDATION/ANALGESIA - memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage, and the need to be transferred to a hospital.

Additional comments/risks:

_____

_____

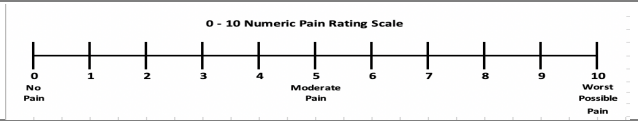
I understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

I have been given an opportunity to ask questions about my anesthesia/analgesia methods, the procedures to be used, the risks and hazards involved, and alternative forms of anesthesia/analgesia. I believe that I have sufficient information to give this informed consent.

_____	__/__/__	_____	__/__/__	_____	__/___/___
Patient Signature	Date	Witness Signature	Date	Surgeon Signature	Date

PELOSI MEDICAL CENTER

PREOPERATIVE CARE RECORD

Immediate Preoperative Evaluation					
Procedure Date: _____/_____/_____		Driver's Name/Phone:			
Arrival Time: _____ :_____		Last time patient ate/drank: ____:____ ☐ today ☐ yesterday Describe intake:			
Pt ID verified: Yes / No		**Urine Pregnancy Test result** __ (neg.) __ (pos.) __ (n/a: age > 55 or hysterectomy)			
Vital Signs:	BP:	HR:	RR:	TEMP: ° F	Wt: lbs
Pre-Op Meds Taken:					
Pain Scale Score: _____ (0 – 10) If pain, onset ____/____/____. _____ AM/PM Location: _____					

Patient Medical/Surgical History					
Yes	**No**		**Yes**	**No**	
		Recent skin injuries			Sleep apnea
		Rash			Snoring
		MRSA (Methicillin-resistant staph aureus)			Positive HIV test
		Skin infection			Gastrointestinal problems
		Bleeding disorder			Liver problems
		Blood clots			Hepatitis
		Unusual reaction to anesthesia			Kidney problems
		Serious back or nerve injury			Diabetes
		Smoker: ☐ Past ☐ Current # packs/day ____			Hypoglycemia
		Chronic cough			Breast implants
		Lung problems			Glaucoma
		Heart problems			Drugs/Substance Use: _____
		Palpitations			_____
		Hypertension			_____
Past Surgeries/Comments: _____ _____					

Pre-op Documentation Present			Belongings/Valuables		
Yes	**No**		**Yes**	**No**	
		Completed History &Physical Exam			Hearing Aid
		Signed Informed Consent			Eyeglasses
		Lab Results (reviewed by physician)			Contact lenses
					Dental appliances
					Jewelry, cash, or other valuables
					If yes to above, Patient Valuables form (no. 063) completed

Preoperative Teaching		
Yes	**No**	
		Patient positioning during procedure
		Local anesthetic infiltration procedure
		Surgical procedure
		Pain control
		Other:

RN/Surgical Technician Signature: _____

Pelosi Medical Center

OPERATING ROOM RECORD

Date: ____/____/____	Time in OR: :	Surg. Start: :	Surg. End: :
Surgeon:	Anesthesiologist:	Surgical Technician # 1:	RN:
Surgeon Assistant:		Surgical Technician # 2:	

IV: ☐ NS ☐ RL _____ml bag started with __ gauge catheter in _____ by _____

TUMESCENT ANESTHESIA

		Bag #:	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	**TOTALS**
Normal Saline (0.9%)			1000 ml	1000 ml	1000 ml	1000 ml	1000 ml	1000 ml	1000 ml	1000 ml	
Sodium Bicarbonate			10 mEq	10 mEq	10 mEq	10 mEq	10 mEq	10 mEq	10 mEq	10 mEq	
Epinephrine (mg)											
Tranexamic Acid (mg)											
Lidocaine (mg)	(A)										
mls of bag infiltrated	(B)										
Initial mls in bag	(C)										
Lidocaine mg infiltrated	Ax(B/C)										

ESU: Ground Pad placed on _____ **Machine**: ☐ Ellman ☐ Covidien Cutting: ____ Coagulation: ___

2-Way 16 Fr Foley Catheter inserted pre-op: ☐ Yes ☐ No

Skin Prep Used: ☐ Betadine Scrub ☐ Betadine Solution ☐ Hibiclens Solution

Pre-op Dx:	Post-op Dx:

Procedure(s) Performed:

Counts: **Sharps** ☐ correct ☐ incorrect **Instrument** ☐ correct ☐ incorrect ☐ n/a
Sponge/Lap Pad ☐ correct ☐ incorrect ☐ n/a

Surgical Checklist Completed: ☐ Signature: _____

Intraoperative Notes:

Intake Total Volume IV Fluid Infused _____ ml	Total Tumescent Anesthetic Solution __ ml
Output Voided…..... x _____ Foley Cath ..... _____ ml	Total Volume Aspirated ___ ml - Total Infranatant Fluid _____ml Total Supranatant Fat _____ ml Total Weight Supranatant Fat (*Total Supranatant Fat ÷ 480*) = _____lb
	Fat Transfer to _____ _____ ml Fat Transfer to _____ _____ ml Fat Transfer to _____ _____ ml

Patient recovered in OR at ___:____ **PHYSICIAN SIGNATURE:** _____

PELOSI MEDICAL CENTER

ANESTHESIA RECORD

Date:	Anesthesia Start:	Surgery Start:	Surgery End:	Anesthesia End:
Surgery:		Surgeon:	Ht:	Wt:

Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Diazepam (mg PO)																						
Diphenhydramine (mg PO)																						
Oxycodone (mg PO)																						
Midazolam (mg IM / IV)																						
Fentanyl (mcg IM / IV)																						
Glycopyrrolate (mg IM / IV)																						
Metoclopramide (mg IM / IV)																						
Ondansetron (mg IM / IV)																						
Propofol (mcg/kg/min IV)																						
Oxygen (L/min)																						
ECG																						
O_2 Sat %																						
$ETCO_2$																						
Temp																						
Fluids																						

Pre-Sedation

BP:

Pulse:

RR:

SaO_2:

Monitors

- ☐ EKG
- ☐ $ETCO_2$
- ☐ SaO_2
- ☐ NIBP
- ☐ TEMP
- ☐ Other

ET# _____

LMA# _____

- ↓ Systolic BP
- ↑ Diastolic BP
- • Pulse
- O Respirations

220 – 200 – 180 – 160 – 140 – 120 – 100 – 80 – 60 – 40 – 20 –

Anesthesia Notes/Complications:

Antibiotic: _____ ____ Gm IVPB at ____:____

Patient Position: _____ ☐ Pressure points checked and padded

IV Fluid ____ ml
EBL ____ ml
Urine ____ ml

Signature: _____

PELOSI MEDICAL CENTER

ANESTHESIA RECORD

Date:	Anesthesia Start:	Surgery Start:	Surgery End:	Anesthesia End:
Surgery:		Surgeon:	Ht:	Wt:

Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Diazepam (mg PO)																						
Diphenhydramine (mg PO)																						
Oxycodone (mg PO)																						
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Propofol (mcg/kg/min IV)																						
Oxygen (L/min)																						
ECG																						
O_2 Sat %																						
$ETCO_2$																						
Temp																						
Fluids																						

Pre-Sedation

BP:

Pulse:

RR:

SaO_2:

Monitors

- ☐ EKG
- ☐ $ETCO_2$
- ☐ SaO_2
- ☐ NIBP
- ☐ TEMP
- ☐ Other

ET# _____

LMA# _____

- ↓ Systolic BP
- ↑ Diastolic BP
- • Pulse
- O Respirations

220 – 200 – 180 – 160 – 140 – 120 – 100 – 80 – 60 – 40 – 20 –

Anesthesia Notes/Complications:

Antibiotic: _____ ____ Gm IVPB at ____:____

Patient Position: _____ ☐ Pressure points checked and padded

IV Fluid ____ ml
EBL ____ ml
Urine ____ ml

Signature: _____

PELOSI MEDICAL CENTER

POSTOPERATIVE CARE RECORD

Date:																					
Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Oxygen (L/min)																					
ECG																					
O_2 Sat %																					
$ETCO_2$																					
Temp																					
Fluids																					
220 --																					
200 --																					
180 --																					
160 --																					
140 --																					
120 --																					
100 --																					
80 --																					
60 --																					
40 --																					
20 --																					

Monitors

- ☐ EKG
- ☐ SaO_2
- ☐ NIBP
- ☐ TEMP
- ☐ Other _____

ET# _____

LMA# _____

- ↓ Systolic BP
- ↑ Diastolic BP
- • Pulse
- O Respirations

Postoperative Care and Discharge Plan

Yes	No	n/a	
			Dressings applied.
			Compression garment(s) applied: Type _____size _____
			IV access discontinued with cannula intact & no redness or edema noted.
			Foley catheter removed.
			Patient given written discharge instructions. A copy remains in the chart.
			A responsible adult is present to take the patient home.

Medications given Post-op

Time	Medication	Dose	Route
_____	_____	_____	____
_____	_____	_____	____

_____

Signature of MD/RN administering meds

1. Consciousness		3. Respiratory		5. Circulation		7. Pain		9. Oral Intake	
Conscious, fully awake	2	Deep breaths & cough freely	2	BP +- 20% of baseline	2	Pain free	2	Tolerates fluids w/o PONV	2
Arousable when spoken to	1	Dyspnea	1	BP +- 50% of baseline	1	Mild pain	1	Minimal nausea and no vomiting	1
Not responsive	0	Requiring assistive ventilation	0	BP > +- 50% of baseline	0	Unusual or excruciating pain	0	Nausea and vomiting	0
2. Activity		**4. Oxygenation**		**6. Dressing**		**8. Ambulation**		**10. Urine Output**	
Moves 4 extremities	2	Room air sats >92%	2	Dry	2	Able to ambulate appropriately	2	Voided	2
Moves 2 extremities	1	O_2 to maintain sats >90%	1	Wet but stationary	1	Dizziness or vertigo when erect	1	Has not voided	0
Cannot move extremities	0	O_2 sats <90% despite O_2	0	Wet but growing	0	Dizziness or vertigo when supine	0		

Total Aldrete Score: ____ **Score must be 18 – 20 to meet discharge criteria**

Time	Notes

Discharged from Center at ____:____ to _____ Physician Signature: _____

PELOSI MEDICAL CENTER

Cosmetic Labiaplasty Operative Report

Date of Procedure: _____ **Surgeon/Assistant**: _____

Anesthesia/Anesthesiologist: _____

Height/Weight/Parity: ___ft___ in / _____ lbs / _____

Fluid Intake: _____ ml **EBL**: _____ ml **Drains**: ☐ None ☐ Jackson-Pratt

IV Antibiotics: ☐ None ☐ Yes _____

Pre-Operative Diagnosis: ☐ Labia Minora ☐ Hypertrophy ☐ Hyperpigmentation ☐ Asymmetry
☐ Bilateral ☐ Left ☐ Right

☐ Clitoral Hood Hypertrophy
☐ Bilateral ☐Left ☐ Right

☐Primary Procedure ☐ Revisionary Procedure

Post-Operative Diagnosis: Same

Procedure: ☐ Labia minora reduction labiaplasty
☐ Clitoral hood contouring
☐ Other:_____

Condition: _____

Clinical Findings:

This is a ____year-old female with a preoperative diagnosis described above requesting elective cosmetic surgery and presenting with normal gynecologic anatomy; she denied any vulvovaginal pelvic symptomatology and denied any symptoms of pelvic floor defects. After a discussion of the risks, benefits and expected outcomes of the procedures described above and of all treatment alternatives, she signed a statement of written informed consent.

Description of Procedure:

☐ The patient was brought to the operating room and kept awake because she requested local anesthesia.
☐ The patient was brought to the operating room and placed under an adequate level of anesthesia.

She was then prepped and draped in the usual sterile fashion for vaginal surgery with anti-embolic stockings & sequential compression stockings applied.

☐ The labia minora were exposed, inspected and marked for incision bilaterally.
☐ The clitoral hood was exposed, inspected and marked for incision bilaterally.

The marked tissue was injected with a dilute solution of lidocaine and epinephrine for anesthesia and hemostasis. Incisions were made using a combination of ☐sharp dissection, ☐electrosurgical dissection, ☐radiofrequency dissection, ☐CO_2 laser dissection. The marked tissue was excised and hemostasis was achieved with ☐ absorbable sutures ☐ electrocautery ☐ other:_____.

Meticulously-placed, interrupted sutures of ☐ No. 5-0 Monocryl ☐ other:_____ were used to align and approximate the edges of the remaining tissue in a cosmetic and hemostatic fashion. Hemostasis was confirmed at all surgical sites.

Antibiotic ointment was placed over all incision lines and a light dressing was placed. The patient tolerated the procedure well and was brought to the recovery room in stable condition.

_____ _____
Surgeon Signature Date