

Perineo-, Colpoperineoplasty, Rectocele 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
COSMETIC VAGINOPLASTY
POST-OPERATIVE INSTRUCTIONS

Below are post-operative instructions and information on what to expect during your post-operative recovery period. This information applies to the following procedures:

- Perineoplasty
- Colpoperineoplasty
- Rectocele Repair

If, during your post-operative course, you have a question or concern, contact Dr. Pelosi at **201-858-1800**. During business hours you will talk to the office staff directly. After hours you will be connected to our answering service and Dr. Pelosi will either be connected directly to you or he will call you back. If you do not hear from us in 15 minutes, call the answering service again.

Discharge from the Facility

Make sure that you purchase the medications prescribed to you by your surgeon.

Home/Hotel

You were given a local injection of a long-acting anesthetic during surgery. The purpose is to provide you with post anesthesia comfort for 8 to 10 hours. Afterwards, take the analgesics that were prescribed to you as needed. Analgesics (pain medications) work best if you start taking it before discomfort gets too intense. Mild pressure and cramping sensations are normal after this type of surgery.

The First Postoperative day

The first day you should rest, eat light according to your appetite, drink fluids, and take your medications as prescribed.

If you have a bladder catheter and/or vaginal packing, it will be removed on the first postoperative day in our office. Follow the instructions below in caring for your catheter and drainage bag:

- The tubing from the leg bag should fit down to your calf with your leg slightly bent. If you have extra tubing, you may need to cut it. The clinical staff will show you how to do this.
- Always wear the leg bag below your knee. This will help it drain.
- Make sure to place the leg bag on your calf with the Velcro® straps your nurse gave you. Use a leg strap to secure the tubing to your thigh.
- If the straps leave a mark on your leg, they are too tight and should be loosened. Leaving the straps too tight can decrease your circulation and lead to blood clots.
- Empty the leg bag into the toilet through the spout at the bottom every 2 to 4 hours, as needed. Don't let the bag become completely full.
- Don't lie down for longer than 2 hours during the day while you are wearing the leg bag.
- At night keep the leg bag below the level of your bladder. To hang your leg bag while you sleep, place a clean plastic bag inside of a wastebasket. Hang the leg bag on the inside of the wastebasket.

Dieta durante las primeras 4 semanas de curación

Try to avoid eating foods that produce constipation for the first 4 weeks. Eat a diet high in fiber, vegetables, fruit and water. If you are prone to constipation, take Colace 100mg twice a day. This is a stool softener. If you are still constipated, take a Fleet enema (purchased at any pharmacy) and use as directed. Keep in mind that narcotic analgesics (Percocet, Vicodin, Oxycontin) produce constipation as a side effect.

How to Stay Comfortable During Healing

If you have discomfort in the first 12 hours after surgery, take an analgesic (pain medication). **Do not apply a cold pack or ice pack.**

If you have discomfort in the first few days after surgery, place a COLD (NOT ICE) pack on the perineum (the area between vagina and anus) or take an analgesic (pain medication). Do not keep the cold pack on continuously. Apply it

Pelosi Medical Center
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for 5 to 10 minutes then remove it for a while and then place it again. Continue this process until you are ready to retire for the night. You do not have to use the cold pack while you sleep. If you do not have discomfort, do not use a cold pack.

To improve comfort while sitting, use a ring cushion to keep pressure off the area.

Commonly Seen After This Type of Procedure

Some women with hemorrhoids may develop temporary hemorrhoidal swelling after surgery. Although this is a nuisance, it is a self-limiting problem that will resolve over time. If this inflammation should develop, call Dr. Pelosi and he will give you instructions in the care of this condition and medications to assist in reducing discomfort and produce resolution.

Light vaginal bleeding is common in the first six weeks of healing. However, contact us if you note vaginal bleeding so we can determine if any special care is necessary.

Perineal Hygiene for the First 4 Weeks of Healing

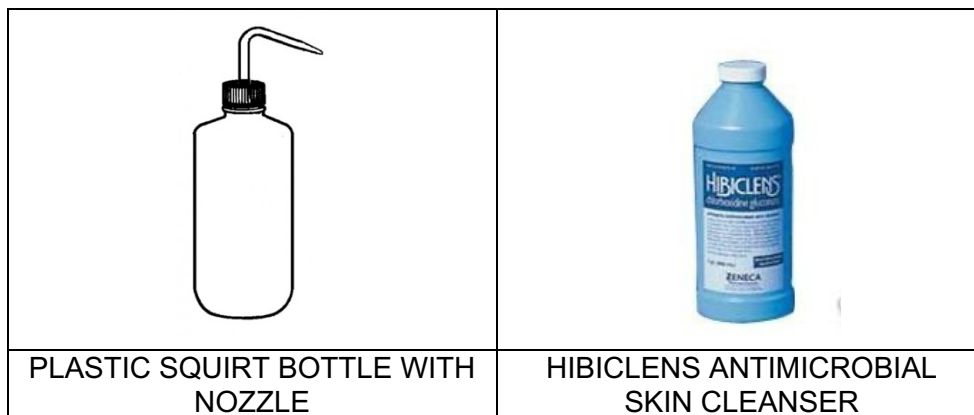
You may shower the day after surgery.

Do not take tub baths, Sitz baths, Epsom salt baths, Jacuzzi, etc. for the first 8 weeks because it will cause your stitches and surgical site to soften, weaken and possibly separate.

You should not apply any creams, lotions, ointments, hydrogen peroxide, alcohol, etc to the area unless you have been instructed to do so by your surgeon. Many topical compounds can interfere with the healing process and create problems.

Cleaning the perineal area:

1. Obtain the following items from the pharmacy a few days before surgery:



2. Fill the squirt bottle with 1-part Hibiclens to 20-parts water. Use this solution to rinse the surgical site after bowel movements and urination for the first fourteen (14) days after surgery. Avoid touch
3. 00.
4. ing the area with fingers when possible to decrease risk of infection. When using toilet tissue, do not rub on the stitches.
5. DO NOT under any circumstance pull or tug on the skin anywhere near the stitches.
6. You may shower and gently wash the vaginal area with the bottle of Hibiclens solution or mild soap and water.
7. When using the toilet, gently dab with toilet tissue and avoid forceful rubbing over the perineum. Finish by spraying the Hibiclens solution on the perineum and allowing it to air dry.

Restrictions on Sex and Other Activities

Pelosi Medical Center
COSMETIC VAGINOPLASTY
POST-OPERATIVE INSTRUCTIONS

You may not have sex, place anything into the vagina, or go swimming until you have completely healed from surgery. Complete healing takes six (6) to eight (8) weeks for most women. You should make an appointment to be examined by Dr. Pelosi six (6) weeks after surgery. He will inform you if you are ready to resume these activities. If you cannot see Dr. Pelosi six (6) weeks after surgery, we recommend that you wait until eight (8) weeks after surgery before resuming these activities.

Post-op Follow-up

Contact the office at **201-858-1800** within one week after your procedure to schedule a post-op visit.

Patient's acknowledgment of receipt of instructions:

Patient's Signature

____/____/____
Date

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? <input type="checkbox"/> YES <input type="checkbox"/> 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: \$ _____ \$ _____ \$ _____	___/___/___ ___/___/___ ___/___/___	___ ___ ___	_____

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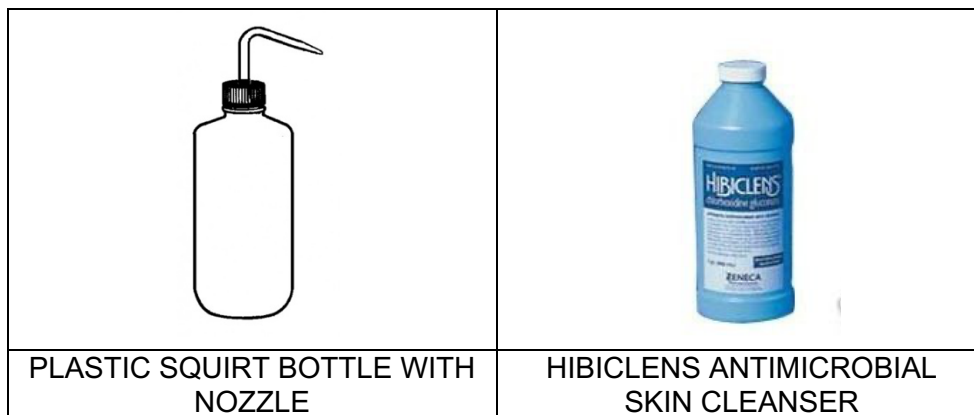
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Signs and Symptoms of PE

- 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)	
<input type="checkbox"/> 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 _____ (patient signature) Other _____ (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 _____

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

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

TOTAL RISK FACTOR SCORE _____

Score	Risk Level	Prophylaxis for Surgical Patients
0-2	Low	<ul style="list-style-type: none"> • Early ambulation
3-8	Increasing	<ul style="list-style-type: none"> • 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%	<ul style="list-style-type: none"> • Not a candidate for office-based surgery

PELOSI MEDICAL CENTER

PHYSICIAN PERIOPERATIVE ORDERS

PRE-OPERATIVE

Enter 'x' next to medication & circle prescribing dose

<input type="checkbox"/> DiphenHYDRAMINE	25 / 50 mg PO x 1	<input type="checkbox"/> CefTRIAxone	1 gm (< 79 kg) 2 gm (≥ 79 kg) 3 gm (≥ 120 kg) IV Piggyback x 1
<input type="checkbox"/> Diazepam	10 / 20 mg PO x 1	<input type="checkbox"/> Clindamycin	600 mg (< 70 kg) 900 mg (≥ 70 kg) IV Piggyback x 1
<input type="checkbox"/> FentaNYL	50 / 75 / 100 mcg IM x 1	<input type="checkbox"/> Cephalexin	500 / 1000 mg PO x 1
<input type="checkbox"/> Midazolam	2 / 4 / 6 / 8 mg IM x 1	<input type="checkbox"/> Doxycycline	100 / 200 mg PO x 1
<input type="checkbox"/> 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)	Bag #	Lidocaine (mg)	Epinephrine (mg)	Sodium Bicarbonate 8.4% (ml)
1			10		6			10
2			10		7			10
3			10		8			10
4			10		9			10
5			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
LVR/COLPOPERINEOPLASTY 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):

**Laxity of the perineum (the outer vaginal opening and outer muscles), and/or
Laxity of the vaginal canal (the anterior and/or posterior vaginal walls), and/or
Laxity of the levator muscles (the inner vaginal muscles, also known as Kegel muscles), and/or
Rectocele if noted at the time of surgery (a hernia-like weakness of the posterior vaginal wall)**

2. The medical/surgical treatment proposed is:

**Perineoplasty (reduction and tightening of the perineum with suturing), and/or
Colpoperineoplasty (reduction and tightening of the inner vaginal walls with suturing), and/or
Levatorplasty (tightening of the levator muscles (Kegel muscles) with suturing, and/or
Rectocele repair (reinforcement of the posterior vaginal wall with suturing).
Procedure may include laser surgery and/or radiofrequency surgery.
Procedure may include temporary vaginal packing and/or bladder catheterization.**

(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:
- The purpose and extent of the procedure to be performed;
 - The risks involved in the proposed procedure, including those, which, even though unlikely to occur, involve serious consequences.
 - The possible or likely results of the proposed procedure;
 - The feasible alternative procedures and methods of treatment;
 - The possible or likely results of such alternatives;
 - 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.

Pelosi Medical Center
LVR/COLPOPERINEOPLASTY CONSENT

- 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.
- 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: ____:____ <input type="checkbox"/> today <input type="checkbox"/> 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: <input type="checkbox"/> Past <input type="checkbox"/> 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 (<i>Total Supranatant Fat ÷ 480</i>) = _____ 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	220																		
BP:	200																		
Pulse:	180																		
RR:	160																		
SaO ₂ :	140																		
	120																		
Monitors	100																		
<input type="checkbox"/> EKG	80																		
<input type="checkbox"/> ETCO ₂	60																		
<input type="checkbox"/> SaO ₂	40																		
<input type="checkbox"/> NIBP	20																		
<input type="checkbox"/> TEMP																			
<input type="checkbox"/> Other _____																			
ET# _____																			
LMA# _____																			
↓ Systolic BP																			
↑ Diastolic BP																			
• Pulse																			
O Respirations																			
Anesthesia Notes/Complications:																			
Antibiotic: _____ Gm IVPB at _____										IV Fluid _____ ml									
Patient Position: _____ <input type="checkbox"/> Pressure points checked and padded										EBL _____ ml									
										Urine _____ ml									
															Signature: _____				

PELOSI MEDICAL CENTER

POSTOPERATIVE CARE RECORD

Date:																	
Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Oxygen (L/min)																	
ECG																	
O ₂ Sat %																	
ETCO ₂																	
Temp																	
Fluids																	
Monitors	220 --																
	200 --																
	180 --																
	160 --																
	140 --																
	120 --																
	100 --																
	80 --																
	60 --																
	40 --																
20 --																	
0 Respirations																	

EKG
 SaO₂
 NIBP
 TEMP
 Other _____
 ET# _____
 LMA# _____
 ↓ Systolic BP
 ↑ Diastolic BP
 • Pulse
 O Respirations

Postoperative Care and Discharge Plan													
Yes	No	n/a								Medications given Post-op			
										Time	Medication	Dose	Route
			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.							Signature of MD/RN administering meds			
			A responsible adult is present to take the patient home.										
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 Vaginoplasty Operative Report

Date of Procedure: _____ Surgeon/Assistant: _____

Anesthesia/Anesthesiologist: _____

Height/Weight/Parity: ___ ft ___ in / ___ lbs / _____

Fluid Intake: _____ ml EBL: _____ ml Drains: None Jackson-PrattIV Antibiotics: None Yes _____Pre-Operative Diagnosis: Vaginal Laxity Rectocele Cystocele Other: _____
 Primary Procedure Revisionary Procedure

Post-Operative Diagnosis: Same

Procedure: Perineoplasty
 Colpoperineoplasty
 Rectocele Repair
 Cystocele Repair
 Other: _____

Condition: _____

Clinical Findings:

This is a ___ year-old female with a preoperative diagnosis described above requesting elective cosmetic surgery. 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 targeted dimensions of the vaginal introitus were established by careful digital assessment and surgical markings were made on the perineum. 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, CO₂ laser dissection.

A flap of perineal skin and subcutaneous fat was made and advanced to the level of the posterior vaginal wall. After mobilizing the bulbocavernosus muscles bilaterally, the posterior vaginal wall and the rectovaginal space were injected with the same local anesthetic. A triangular excision of the posterior vaginal wall was marked and the posterior vaginal wall was undermined and excised sharply. Hemostasis was achieved with absorbable sutures electrocautery other: _____.

Since perineoplasty only was planned, no additional dissection was carried out and the vaginal wall incision edges were closed with a running suture of No. 2-0 Vicryl.

Since colpoperineoplasty was planned, additional undermining of the posterior vaginal wall was carried out lateral and superior to the excised tissue to expose the rectovaginal fascia and the levator ani muscles. No rectocele was present. A rectocele was noted and repaired with running sutures of No. 2-0 Vicryl in ___ layers with transrectal palpation throughout this process to avoid rectal wall injury. The levator ani muscles were approximated in the midline to the desired degree of tightness using No. 0 Quill in ___ layers with transrectal palpation throughout this process to avoid rectal wall injury. Hemostasis was confirmed and the surgical field was irrigated with sterile saline. The vaginal wall incision edges were closed with a running suture of No. 2-0 Vicryl.

The deep tissues of the perineal body were approximated with No. 2-0 Vicryl No. 0 Quill Other: _____ incorporating the bulbocavernosus muscles and the deep and superficial transverse perineal muscles. The skin was approximated with interrupted sutures of No. 4-0 Monocryl. Hemostasis was confirmed at all surgical sites.

A foley catheter was not placed was placed. Vaginal packing was not placed was placed. Antibiotic ointment was placed over all incision lines and vaginal packing was employed. The patient tolerated the procedure well and was brought to the recovery room in stable condition.

Surgeon Signature_____
Date