MARINA PLASTIC SURGERY by Athēnix

4560 Admiralty Way, Suite 108/255/256
Marina del Rey, CA 90292
P: 310.827.2653 · F: 310.823.1984

Smoking Informed Waiver and Consent for Elective Cosmetic Surgery

Smoking, Second-Hand Smoke Exposure, ANY form of Nicotine Products (Patch, Gum, Nasal Spray, Vape pens, lozenges, etc.): Patients who are **currently smoking or use tobacco or nicotine products** excessively (patch, gum, or nasal spray, vape pens, lozenges, etc.) are at a greater risk for significant surgical complications of surgical infections, delayed healing, and additional scarring. Individuals exposed to **second-hand smoke** are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and cause complications from anesthesia recovery, such as pneumonia, excessive coughing, and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of these types of complications. Please indicate your status regarding these items below**:**

I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing surgical complications.

I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of excessive nicotine products.

I have smoked and stopped approximately _________ days/weeks/months/years ago. I understand I may still have the effects and therefore risks from smoking in my system, if not enough time has lapsed.

It is important to refrain from smoking at least 4-6 weeks before and after surgery. I acknowledge that I will inform my physician if I continue to smoke within this time frame, and understand that for my safety, a nicotine urine test may be performed, and the surgery may be delayed if it is found to be positive and your surgeon feels your smoking represents an unacceptable risk. You will also be charged in accordance with our cancellation policy if found positive for nicotine the day of surgery.

______________________________ ______________________________
PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE & TIME**

______________________________ **SELF OR** ______________________________
PRINT PATIENT/REPRESENTATIVE NAME **RELATIONSHIP TO PATIENT**

______________________________ ______________________________
WITNESS SIGNATURE **DATE & TIME**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRACTICE NAME:______________________________

PHYSICIAN:______________________________

ADDRESS:______________________________

BY REPRESENTATION OF SIGNATURE BELOW, I HEREBY AUTHORIZE THE ABOVE STATED OFFICE TO FORWARD MY MEDICAL RECORDS TO:

NORTHWEST SURGICAL DEVELOPMENT OF MARINA DEL REY, LLC
4560 ADMIRALTY WAY, SUITE 256
MARINA DEL REY, CA 90292
PHONE: 310.827.2653 * FAX : 310.823.1984

______________________________ ______________________________
PATIENT SIGNATURE DATE

____
PRINTED NAME