

Fairfield County Plastic Surgery  
**Postop instructions**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Postop instructions

Specific wound care \_\_\_\_\_  
\_\_\_\_\_

Limitation of activity \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dietary restrictions \_\_\_\_\_  
\_\_\_\_\_

Instructions about medications inc side effects \_\_\_\_\_  
\_\_\_\_\_

Hygiene related to procedure \_\_\_\_\_  
\_\_\_\_\_

Follow-up appointment \_\_\_\_\_  
\_\_\_\_\_

Signature of RN / MD \_\_\_\_\_

Signature of Patient/ Guardian \_\_\_\_\_