



Emerge Medical Spa
7455 SW Bridgeport Rd Ste 240
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Emerge Medical Spa

Fraxel re:store Procedure: Pre-operative Instructions

1. Before we start, please review the consent form thoroughly and make sure all your questions are answered.
2. Your treatment is scheduled on _____. You will be here for approximately 2 hours.
3. Please start taking Valtrex on _____, if applicable. Take 1 tablet, twice a day until you finish all tablets we give you.
4. If applicable you need to stop taking Aspirin or other pain medication such as Motrin, Celebrex, Aleve, and Ibuprofen, 10 days before the procedure, that is, _____. You may take Tylenol (acetaminophen) for pain.
5. Please let us know if you are on any herbal or non-prescription supplements.
6. Please have the following items ready before your treatment day:
 - Home environment: make sure that you have a room is free from direct sunlight. Blinds and drapes are sufficient. Vacuum the room and laundry linens to cut down risk of infection.
 - Sunblocks with SPF 30 or above: once the skin is healed, you will be instructed to apply sunscreen liberally for 3 months.
7. On the day of treatment, please come to the office with no make up and a lower-cut, buttoned shirt. Do not wear contact lenses for that day.

Fraxel re:store Procedure: Post-operative skin care

1. Hand-washing is the most important thing you can do to prevent infection.
2. To reduce swelling and for pain relief, you may place ice packs, bags or frozen peas on the treated area in 20 minute increments. You may also take Tylenol 500 mg, two tablets, every 6 hours.
3. Keep your head elevated while resting, and for the first few nights. This helps reduce swelling and promote healing.
4. Remember to finish all of your oral medication as/if prescribed, Valtrex.
5. Call us if you experience any one of the following:
 - Pain that is not relieved by Tylenol.
 - Excessive redness, swelling.
 - Excessive itching.
 - or, if you are just not sure. If you cannot reach us and it is an emergency, call 911.
6. Do not use glycolic, retinoids, or salicylic product for 1 week post treatment.

By signing below, I acknowledge that I have read and understood the information written above, and a copy was given to me. I agree to follow all above instructions.

Name _____ Signature _____ Date _____