Post Care Instructions
PDO Threads Treatment

Patient Name: _____

Treatment Areas: _____

Name of Injector: _____

Congratulations on your EuroThreads treatment. To ensure optimal treatment results it is important that you read this information carefully. Please sign this form below indicating that you have read these instructions in their entirety and that you fully understand the need to notify our office immediately if you are experiencing any adverse effects or abnormalities not listed below.

Treatment Results

1. It may take a minimum of 2 plus weeks for treatment results to become noticeable.
2. Minor bruising and swelling in formal and to be expected.
3. Lumps and/or bumps may temporarily occur at or along treatment site(s). These will resolve with time and are seldom a cause for concern.
4. Minor pain at the injection site is normal and to be expected. Pain may last up to a week post treatment.
5. Asymmetry and irregularity of tissues treated is common post treatment and usually resolves itself.

Due Diligence

1. Avoid exercise for 24 hours after treatment.
2. Diligently follow your practitioner's instructions with the use of antihistamines if you are prone to seasonal allergies.
3. if you experience severe weather or dramatic atmospheric pressure changes in your geographic location, you may experience greater than normal swelling or complications.
4. Avoid excessive chewing and hard foods for 3 days post treatment. Do not drink through a straw.
5. Avoid animated facial expressions for a week post treatment.
6. To avoid additional swelling, sleep with your head elevated for 2-3 days post treatment.
7. Avoid massaging treatment area(s) excessively.
8. Avoid washing your face for 12 hours following treatment.
9. Do not wear makeup or apply facial creams for 48 hours following treatment.

Contact us at (754) 600-9373 if you:

1. Experience increased redness, swelling or pain at the injection site.
2. Have one or more threads begin to extrude.
3. Have additional questions or concerns regarding your treatment / treatment follow-up.

Patient Signature: _____ Date: _____

Dr. Signature: _____