



LUIS A. ESCOBAR, M.D.

## Hollywood Office

4350 Sheridan Street Suite 102

Hollywood, Florida 33021

Tel: (954) 322-8586

Fax: (954) 322-8581

Located east of 46<sup>th</sup> Avenue and Sheridan Street in  
The Oaks Office Center

### Pre-Procedure Instructions

- **No Aspirin or Plavix** for 7 days (or any medications containing Aspirin) If needed, **Tylenol** is okay to take in place of Aspirin.
- **NO ANTI-BIOTICS** if any infections **PLEASE NOTIFY THE OFFICE IMMEDIATELY!**
- **NO COUMADIN** or any other blood thinners for 5 days.
- Any **DENTAL** or **OTHER PROCEDURES** (please contact the office). Please notify the office if you become sick or injured prior to procedure.
- **No Anti-Inflammatories** (Ibuprofen, Aleve, Naprosyn/Naproxen, Motrin, Advil, Voltaren (oral or topical gel), nabumatone, etc..) for 5 days
- No supplement of **Vitamin E or Lovaza** for 7 days (including multivitamin & Fish Oil)
- You may eat **light** breakfast or lunch, you will be laying on your stomach.
- If you take **BLOOD PRESSURE MEDICATION, HEART MEDICATION** and if you are **DIABETIC**. Take your medications as usual
- **DO NOT** stop taking your medications unless directed by physician to do so. If you are not sure if you can take a certain medication please call the office and ask to speak to a nurse or bring medication to your appointment.
- Please wear loose-fitting clothes (elastic-wasted pants, sweats, etc....) for your procedure
- Please arrive @ **scheduled time for your procedure**. You will have to fill out paperwork for each procedure. You may drive yourself to and from appointment as long as you are not taking anything to impair your driving.
- **No lotions or creams** around the area for the day of your procedure

**ALL cancellations must be called in 24 hours ahead of time, I understand that if I dont show up for my scheduled procedure nor speak to an office staff member to cancel the procedure, I will be liable for a fee of fifty dollars (\$50.00). The cost of the medicine and procedure room time that is vital in performing all scheduled procedures.**

**The above instructions have been read to me, a copy given to me and I understand them as explained. I understand that I will be liable for a medicine and procedure room fee if I do not show up, or cancel my schedule appointment.**

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date

APPOINTMENT DATE AND TIME \_\_\_\_\_ at \_\_\_\_\_ AM / PM