

STOP SMOKING CONSENT

Consent for stop smoking 6 weeks prior and 4 weeks after the procedure

Patient Name:

Date of Birth:

Surgeon: Mr Khashaba

Date of Surgery:

Procedure:

I, the undersigned patient, hereby acknowledge and provide consent to the following:

1. I understand that I have been advised by my healthcare provider, [Mr Khashaba], to cease smoking and using all nicotine products **6 weeks prior to and 4 weeks after** the scheduled surgery.
2. I understand that **cigarette smoking** and using **nicotine products** (e.g. Vaping that contains nicotine, Nicotine Gums, Nicotine Patches, etc.) are proven to have detrimental effects on my surgical outcome, including an increased risk of complications, delayed wound healing, infection, and decreased oxygen levels in my blood.
3. I acknowledge that **nicotine** is a highly addictive substance and may require a comprehensive plan to successfully quit prior to the surgery.
4. I understand that I have the responsibility to abstain from smoking and using any nicotine-containing products for **6 weeks prior to the surgery and 4 weeks after**.
5. I acknowledge that it is my responsibility to inform my healthcare provider if I am unable to quit smoking or using nicotine products as instructed prior to the surgery.
6. I understand that my healthcare provider may utilize **nicotine testing** methods to confirm my cessation from smoking and nicotine products.
7. **I acknowledge that failure to comply with the instructions to cease smoking and using nicotine products will result in the postponement or cancellation of my surgery.**
8. I understand that I should inform my healthcare provider of any nicotine replacement therapy (NRT) products or smoking cessation aids I may be using, as these may have specific implications for my surgery.
9. I acknowledge that it is essential to disclose any changes in my smoking or nicotine product usage during the pre-operative period to ensure the safety and success of my surgery.
10. I understand that my healthcare provider and the hospital/surgical centre will make reasonable efforts to support my smoking cessation efforts, which may include providing educational resources and referral to smoking cessation programs.
11. I understand that in case of cancellation or postponement of surgery due to failure on my part to stop smoking or using nicotine-containing products, with a positive nicotine test (a test result showing I still have nicotine in my system), I will be charged by the hospital or my health care provider for booking fees and expenses.

I have read this consent form carefully and fully understand its contents. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. By signing below, I voluntarily provide my informed consent to cease smoking and using all nicotine products prior to the scheduled surgery.

Patient Signature: _____

Date: _____