

**SMOKING RISK CONSENT FORM**

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

Procedure: \_\_\_\_\_

Person Reviewing Smoking Risk: \_\_\_\_\_

Please check one of the following:

\_\_\_\_\_ I am not a smoker.

\_\_\_\_\_ I quit \_\_\_\_\_ months or \_\_\_\_\_ years ago.

\_\_\_\_\_ I currently smoke \_\_\_\_\_ a day.

Smoking, secondary smoke, chewing tobacco, snuff, and other nicotine containing products have been found to have an unfavorable impact on wound healing. Nicotine is a chemical that produces constriction of the blood cells which denies oxygen its place on the red blood cells. Wound healing can be delayed after a procedure if you continue to smoke before and after the procedure. People who consume nicotine are at a higher risk for post procedure infections. It is recommended per Dr. Jim Nelson and colleagues to refrain from smoking, chewing tobacco, snuff and other nicotine containing products prior to and after a procedure conducted at Rickman Family Clinic.

BY SIGNING THIS RISK CONSENT, I ACKNOWLEDGE THAT I UNDERSTAND THE COMPLICATIONS OF SMOKING AND RECEIVING A PROCEDURE AT RICKMAN FAMILY CLINIC. THE RISKS HAVE BEEN FULLY EXPLAINED TO ME AND I WISH TO PROCEED WITH THE PROCEDURE.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_