Plasma Fibroblast Consultation and Consent Form ENTER LOGO HERE

Title _____ First Name _____ Surname _____

Address _____

Suburb _____ Postcode_____ State _____

Occupation _____ Email Address _____

Mobile _____ Home Ph _____

Date of Birth _____ Ethnic Background _____

Family Doctor Name and Contact No:

_____

Emergency Contact Name and Telephone _____ Relationship _____

How did you find out about us?

_____

Area of Treatment:

- ☐ Lower eye
- ☐ Upper eye
- ☐ Forehead
- ☐ Frown Lines
- ☐ Chin
- ☐ Neck
- ☐ Smile Lines
- ☐ Crows Feet
- ☐ Upper Lip
- ☐ Lower Lip
- ☐ Jowl
- ☐ Belly Button
- ☐ Stomach
- ☐ Hands
- ☐ Other (Please List area) _____

Type of Treatment:

- ☐ Wrinkles
- ☐ Fine Lines
- ☐ Stretch Marks
- ☐ Scars
- ☐ Skin Tags
- ☐ Vascular
- ☐ Warts
- ☐ Acne
- ☐ Rejuvenation
- ☐ Pigment

Area(s) of concern:

_____

_____

Have you used any treatments in the area to be treated (if applicable, please specify)?

_____

_____

Do you have any current or chronic medical illnesses? ☐ Yes ☐ No (Details) _____

Do you suffer from Herpes simplex? ☐ Yes ☐ No (Details) _____

Do you have a history or suffer from glaucoma? ☐ Yes ☐ No (Details) _____

Are you currently under a doctor's care? ☐ Yes ☐ No (Details) _____

Are you taking any photosensitising medication? ☐ Yes ☐ No (i.e. Anti-depressants, Antibiotics, St. John's Wart etc?) _____

_____

Are you taking any medication? ☐ Yes ☐ No (Details) _____

Are you on blood thinners (i.e. Aspirin, Warfarin) ☐ Yes ☐ No (Details) _____

Anti-wrinkle injections, dermal fillers, cosmetic tattoos or chemical peels (within 6mths) ☐ Yes ☐ No (Details) _____

_____

Do you smoke? ☐ Yes ☐ No If so, how many? _____

Are you on immune-compromised? ☐ Yes ☐ No (Details) _____

Do you have any allergies? ☐ Yes ☐ No If so, please list _____

Are you Pregnant, intending to be or breast feeding? ☐ Yes ☐ No If so, please list _____

I don't have a history of Keloid scars? ☐ Yes ☐ No If so, please list _____

Do you have a metal implant in the treatment area? ☐ Yes ☐ No If so, please list _____

Have you had any unprotected sun exposure in the area in the last 4 weeks ☐ Yes ☐ No (Details) _____

Are you using prescription strength exfoliants? ☐ Yes ☐ No (Details)_____

Do you have or had any form of cancer? ☐ Yes ☐ No (Details) _____

Do you have a history of vitiligo? ☐ Yes ☐ No (Details) _____

Medical Informed Consent

I consent and authorise *(business name)* to perform Plasma Fibroblast treatment on me. I understand the following points and have had the opportunity to ask questions during my consultation.

In relation to Plasma Fibroblast treatments, I have been advised as follows:

1. Treatment is successful on most clients, but my individual results cannot be guaranteed
2. Most clients require 1-4 treatments to achieve results, some may require more. Individual results depend on many factors; thus it is extremely difficult to advise on exact number of treatments required
3. Darker skin type clients will require additional treatments due to low intensity application
4. Exposure to UV Rays will compromise my treatment, therefore I will use SPF 30+ sunscreen
5. Avoid wetting and/or touching the area for 48 hours post treatment
6. Not following the program regarding timing of treatments and after care advice will reduce/affect efficacy of my treatment

In relation to Plasma Pigment, Vascular, Scar & Skin tag treatments, I have been advised as follows:

1. Treatment is successful on most clients, but my individual results cannot be guaranteed
2. Most clients will require 2- 4 treatments for successful results
3. Micro-crusting will occur, and I will not scratch, pick, rub or abrade the treatment area
4. Exposure to UV Rays will cause pigmentation to darken again, skin care is essential
5. Vascular lesions may re-appear within 7 days after treatment, whilst the capillary is still compromised, a further treatment is highly recommended within 14 days, Failure to do so, will reduce efficacy of treatment
6. Avoid wetting and/or touching the area for 24 hours post treatment

Risks associated with Plasma Fibroblast treatment

Even though the risk of complication is extremely low, the following can occur: (Please Tick)

- ☐ Pigment changes (light or dark spots on the skin) lasting 1-6 months. Freckles may temporarily or permanently disappear in treated areas. Other potential risk include crusting, itching, pain, bruising, pimple-like bumps, dry skin, hypopigmentation (lightening of the skin), hyperpigmentation (darkening of the skin), blistering, burns, infection, scabbing, swelling, a very small risk of scarring and a failure to achieve the desired result
- ☐ Allergic or delayed inflammatory reactions can develop. A test patch is performed to ascertain reaction of the skin
- ☐ Prior to initiation of treatment, any pigmented lesions should be correctly identified by a physician to be benign and recommended for plasma treatments. A medical certificate to this effect is required
- ☐ I consent to photographs taken to evaluate effectiveness. Photographs revealing my identity will not be used without consent
- ☐ I understand the sensation of plasma Fibroblast treatment is sometimes uncomfortable and feels like a mild zapping, heat, pricking sensation
- ☐ I am aged 18 years or over (otherwise parent or guardian to sign)
- ☐ I will advise (salon/therapist) of any changes that occur during my treatment that can increase potential risks or reduce efficacy
- ☐ I also understand that there will be no refund for any performed services

In relation to my initial and all subsequent treatments I advise that: (Please Tick)

- ☐ I have not had unprotected sun exposure (including tanning beds and fake tan creams) in the last 4 weeks
- ☐ I have not used mechanical epilation, waxed or tweezed in the treatment area in the last 72 hours
- ☐ I have no history of seizures and I have disclosed all known allergies (e.g. Latex, etc)
- ☐ I am not taking medications causing photosensitivity (prescription/non-prescription) e.g. Anti-depressants, St John's Wort, Anti-coagulants, etc
- ☐ I do not have a history of keloid & hypertrophic scar formation
- ☐ I do not have active infections/Immunosuppression
- ☐ I do not have open lesions in the areas to be treated
- ☐ I do not have Herpes I or II – in the areas to be treated
- ☐ I have not used Tretinoin (Retin –A) within the last 2 weeks.
- ☐ I have not had Laser Resurfacing within the last 6 months
- ☐ I have not a Chemical Peel – within the last 4 weeks
- ☐ I have not used Oral isotretinoin/Accutane – within the last 6 months
- ☐ I do not have Diabetes
- ☐ I am not pregnant, breastfeeding and not taking any medication, which may affect treatment outcomes
- ☐ I have received the Pre- and Post-Care Information Sheet. I agree to adhere to all these recommendations
- ☐ Cancellations: (non-refundable deposit for any cancellations less than 48 hours')

I have read all the above and had all my questions satisfactorily answered. Note: Do not sign this form until you have read and understood all the above.

Name in Full _____ Date _____

Signature _____ Clinician (witness) _____

Client Treatment Report (office use only)

Date of Treatment	Clinician Name & Signature	Treatment Details	Settings Used	Amount Paid	Payment Details	Comments

Treatment Series-

I certify that all the information given above is true and I have not had any of the following-

- Sun Exposure in the last 4 weeks
- Change in medication
- Been under doctor's care or supervision
- Any surgery
- Pregnancy/ Trying to be pregnant or breast feeding

Treatment 1-
Signature _____Date _____ Clinician (witness) _____

Treatment 2-
Signature _____Date _____ Clinician (witness) _____

Treatment 3-
Signature _____Date _____ Clinician (witness) _____

Treatment 4-
Signature _____Date _____ Clinician (witness) _____