| | |
|---|---|
| Name | |
| Date of Birth | |
| Address | |
| | |
| Postcode | |
| Email | |
| Telephone | |

**Prior to receiving treatment, please reveal any conditions that may have an effect on this treatment. If you are unsure of any details including personal requirements and potential complications, please discuss with your practitioner.**

| | | |
|---|---|---|
| 1. | Are you currently under a doctor's or specialist's care? If so, for what reason? | YES/ NO |
| 2. | Do you take any over-the-counter or prescription medication or herbal/natural remedies on a regular basis? If Yes, please list. | YES/ NO |
| 3. | Do you have any current chronic or serious medical illnesses such as diabetes, heart disease/angina, epilepsy, hepatitis, blood disorders, cancer? If Yes, please specify. | YES/ NO |
| 4. | Do you have any autoimmune diseases such as psoriasis, lupus, rheumatoid arthiritus or any condition that may weaken your immune system. If Yes, please specify. | YES/ NO |
| 4. | Do you have any known allergies including topical anaesthetics? If Yes, please list. | YES/ NO |
| 5. | Do you have any skin conditions such as acne, rosacea, seborrhoea, facial cold sores (herpes simplex), moles, warts, vitiligo, contact dermatitis or inflammatory skin diseases? If Yes, please list. | YES/ NO |

| | | |
|---|---|---|
| 6. | Do you have or have had any form of cancer? | YES/ NO |
| 7. | Are you currently receiving chemotherapy or radiotherapy? | YES/ NO |
| 8. | Have you taken medication for acne such as oral retinoids (Roaccutane) or benzoyl peroxide in the last 6 months? | YES/ NO |
| 9. | Are you currently taking steroids, anti-coagulants or aspirin on a daily basis? | YES/ NO |
| 10. | Do you have a predisposition to keloid or hypertrophic scars? | YES/ NO |
| 11. | Have you used any products containing topical retinoids (Vitamin A, Retinol, Retin A etc) in the last week? | YES/ NO |
| 12. | Have you used any exfoliants or products containing alpha hydroxy (AHAs), beta hydroxy (BHAs) acids (such glycolic acid, lactic acid, fruit acids) or hydroquinone in the last week? | YES/ NO |
| 13. | Have you had any recent facial surgery or aesthetic treatments such as rhinoplasty, face lift, dermal fillers, PDO threads, Botulinum toxin, aesthetic dental work, tattoos, piercings, laser resurfacing, laser hair removal, micro needling or skin peels? | YES/ NO |
| 14. | Have you had electrolysis, depilatory creams, or waxing on the area to be treated in the last week? | YES/ NO |
| 15. | Have you had any recent sunburn, windburn, cuts or skin abrasions? | YES/ NO |
| 16. | Do you smoke? | YES/ NO |
| 17. | For women:<br>• Are you pregnant or is there any possibility that you are pregnant?<br>• Are you breastfeeding? | <br>YES/ NO<br>YES/ NO |
| 18. | How would you class your skin type based on the Fitzpatrick scale below:<br>  <br>Type 1 — Light, Pale White — Always burns, Never tans<br>Type 2 — White, Fair — Usually Burns, Tans with difficulty<br>Type 3 — Medium, White to Olive — Somtimes mild burns, gradually tans to Olive<br>Type 4 — Olive, Moderate Brown — Rarely burns, Tans with ease to a Moderate Brown<br>Type 5 — Brown, Dark Brown — Very rarely burns, Tans very easily<br>Type 6 — Black, Very dark Brown to Black — Never burns, Tans Very easily, Deeply Pigmented | |
| 19. | Are there any other aspects of your health that have not been identified above and we should be made aware of? | YES/ NO |

I confirm that the information I have supplied is correct, and to the best of my knowledge. I am also confirming that there is no other pertinent medical information to disclose.

Patient's Signature: _____ Practitioner signature:_____

Date: _____ Date:_____

I _____ (patient's name) hereby consent to have a PRP injection procedure. I also consent to any other medical services during the procedure that may become medically reasonable and necessary. This includes, but is not limited to, the administration of anaesthetics necessary to perform PRP injections.

**The treatment**

- I understand that PRP can be used to treat hair loss and for skin rejuvenation and an explanation of the procedure has been given to me.
- I understand that blood will be drawn from a vein in my arm. That blood will then be placed in a PRP machine to be spun down in order to concentrate the platelets and then injected back into the treatment area. I understand pain relief or anaesthetics may be given to reduce discomfort of the PRP injections. I am aware of the pros, cons and alternatives to PRP injections.
- I understand that the PRP injection procedure is an "elective" procedure. If I do not have PRP injections, I will not experience harm or negative consequences for my body.
- I fully understand the results that I may reasonably expect. I understand that not all patients get improvement.
- I understand that multiple treatment sessions may be required and my practitioner has informed me of this. Treatments will be scheduled 4 to 12 weeks apart, and three to six treatment sessions may be required to obtain a result.

## Possible Risks and complications

i. Minor discomfort (pin prick senation) from blood draw
ii. Dizziness and feeling faint (rare)
iii. A temporary headache
iv. Redness in the treatment area for 2 to 4 days
v. Swelling. In some rare cases there may also be swelling or discolouration and bruising associated with the procedure.
vi. Reaction to pain relief or anaesthetic
vii. For hair loss treatment there may be hair loss (temporary) in the existing hair. This is often termed ‘shock loss.’
viii. Infection (very rare)
ix. Itching at the injection sites
x. Pain, minor bleeding and bruising at the sites of injections
xi. Injury to nerve during blood draw (very rare)
I have read and understand all of the possible side effects and complications listed above. I accept the risks of these possible complications and consequences associated with this surgery.

## Post treatment advice

Aftercare is as important as treatment. It is advisable to:
• Refrain from touching the treated areas with hands. This is to reduce the risk of infection at the site of injections.
• Makeup can be applied once the skin has settled - mineral is recommended.
• It is recommended that the use of soaps, other than those recommended by your practitioner, on the treated skin area is restricted until the redness subsides and where possible warm / tepid water and / or gentle skin cleansers are used for cleansing. Do not scrub. Pat to dry only.
• Refrain from intensive sun light (e.g. sunbeds and sunbathing), saunas, steam bath for a period of at least 2 weeks.
• Apply sunscreen with an SPF30+ on a daily basis and with regular applications for a period of at least 2 weeks.
• Avoid electrolysis, waxing, bleaching, exfoliating or applying any other harsh agents to treated area for 72 hours.
• Do not swim in chlorinated water for approximately 14 days.

## Consent to treatment

I confirm that the medical history and medication details that I have supplied are complete and correct and that there is no other medical information I need to disclose.

I understand that withholding any past or present medical information or known allergies may be detrimental to my health and safety during the treatment in which I agree to undertake. If there is any change in my medical history, it is my responsibility to advise the practitioner before further treatments are carried out.

**I understand that there are certain contraindications that would preclude me from receiving treatment such as:**

- **Current infections;**
- **Cancer;**
- **Current chemotherapy treatments;**
- **Skin diseases such as lupus or porphyria;**
- **Liver disease;**
- **Anticoagulation therapy;**
- **Haemodynamic instability;**
- **Severe metabolic or systemic disorders;**
- **Abnormal platelet function (blood disorders);**
- **Underlying sepsis;**
- **Pregnancy;**
- **Current use of corticosteroids;**
- **Steroid injections in my scalp in the last month (for hair loss treatments).**

I confirm that I understand the risks and conditions associated with the treatment. These have been fully explained to me and I have had the opportunity to ask any questions and these have been answered to my satisfaction. Development of any reactions must be reported to the practitioner as soon as possible.

I accept and understand that there are no written, implied, or verbal guarantees as to the anticipated results of this treatment and that the effects of treatment will vary with some patients than with others and that the goal of this treatment is improvement, not perfection. I may require a series of treatments, normally with at least 4 to 12 weeks between procedures, to achieve the maximum cosmetic result. I have been

given post treatment advice and I understand and agree to follow all the aftercare instructions carefully to minimise the risk of side effects.

I confirm that I understand that this is an elective medical-cosmetic treatment and that I have been allowed sufficient time to make a carefully considered decision. This consent was read and signed while I was not under the influence of medications that might alter my mental capacity to understand its contents.

I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents. I was given the opportunity to ask questions about PRP. I consent to the taking of (pre and post-treatment) photographs to monitor treatment effects. Complete patient confidentiality will be maintained at all times.

**I also consent / do not consent (please circle as applicable) to these photographs being used for:**
**Educational purposes: Yes/No**
**Website: Yes/No**
**Social media: Yes/No**

**Treatment Notes**