FIBROBLAST CONSENT FORM

NAME : _____

CONTACT NUMBER : _____

EMAIL : _____

DOB : _____

TREATMENT AREA : _____

Some medical conditions may be contraindication to receiving the procedure, so it is important you provide the information below. It is ultimately your responsibility to ensure that you understand in full the Fibroblast procedure and the expected outcomes before your treatment commences.

Please circle any of the following contraindications that pertain to you.

Cold Sores/Herpes/Shingles
Botox/Fillers within past 21 days
Cosmetic Surgery in past year
Pregnant/Breast Feeding
Cancer
Chemotherapy/Radiation
Keloids
Hyperpigmentation
Cataracts/glaucoma
Frequent Eye Infections
Contact Lenses
Laser Eye Surgery
Diabetes
Hemophilia or any other blood disorder
Blood Thinners

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If you circled any of the above, please explain :

_____

_____

_____

Please initial each paragraph and check yes or no after reading.

_____ I understand post-treatment I may not look my best for the next few days and may potentially experience some minor discomfort, redness and swelling Yes___ No____

_____ Do you have any allergies or have you ever experienced allergic reactions to any kinds of medications, foods or products Yes___ No____

_____ Do you or have you ever suffered an allergic reaction to any local/topical anesthetics Yes___ No___

_____ Are you currently undergoing any medical treatment and/or have you received any medical treatment within the last 6 months Yes___ No____

_____ Are you currently taking any medication This includes any over the counter remedies. Yes___ No___

_____ Do you knowingly have an infectious disease or other acute or chronic disease Yes___ No___

_____ Do you suffer from uncontrolled, high or low blood pressure or any other kind of circulatory issues or defi ciencies Yes___ No___

_____ Do you suffer from dizziness, fainting attacks or any other seizure related condition? Yes___ No___

_____ Do you have any history of cancer? If yes, have you had any radiation or chemotherapy treatment Yes___ No___

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_____ Do you currently have or have you ever been treated for any pigmentation disorders such as Melasma, Age Spots, Hyperpigmentation, Vitiligo and Solar Lentigines etc. Yes___ No___

Do you ever develop dark spots on the skin from wounds Yes___ No___

_____ Are you taking or have you applied any oral/topical steroids or corticosteroids in the last 6 months? This would include Hydrocortisone for Eczema. Yes___ No___

_____ Do you suffer from, or have any problems with scars healing? Do you suffer from keloid scarring, hypertrophic scarring or any other type of scarring Yes___ No___

_____ Do you regularly use Retinol, Glycol, Salicylic Acid or benzoyl peroxide or any other exfoliating products devices (Clarisonic) Yes___ No___

_____ Have you ever had any recent Permanent Make Up (PMU) or cosmetic treatment If so when and did you experience any problems healing Yes___ No___ When _____

_____ Do you have any corneal abrasion or retinal detachment Yes___ No___

_____ Do you have any prosthetic implants or any plates or pins in the area being treated by Fibroblast Yes___ No___

If you answered yes to any of the above, please explain:

_____

_____

_____

_____

_____

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Is there any other ailment or reason not listed you feel we should know about which could prevent us from delivering your treatment? Yes___ No___

Explain _____

_____

Please initial each paragraph after reading.

_____ I acknowledge that this is an elective procedure at my request.

_____ I certify that I have listed all medications/medical procedures/ medical disorders.

_____ Fibroblasting cannot guarantee the exact outcome of this procedure and results may vary from client to client.

_____ I grant consent to photographs being taken BEFORE, DURING and AFTER my Fibroblast procedure.

_____ I certify I have received written post treatment instructions

_____ I agree to follow all aftercare instructions to reduce the risk of post-procedural infection, hyperpigmentation and potential scarring.

_____ I agree to contact Salon D' Shayn with questions or concerns pre or post treatment

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_____ I confirm I have fully read, understood and completed this Medical Conditions and Informed Consent Form and that the procedure known as Fibroblast has been fully explained to me. I have had the opportunity to ask questions about the treatment and that my questions have been answered. I understand the importance of fully revealing my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety both during and after my procedure and I confirm that I have not withheld any medical information. I understand that if there is any change in my medical history it is my responsibility to inform my technician. I understand that for the desired outcome several treatments may be required and this has been explained to me. I also understand no guarantee has been given as to what the outcome of treatment may or may not be. By my signature I affirm that I am at least 18 years old and freely give my informed consent to receiving treatment.

CLIENT NAME : _____

CLIENT SIGNATURE : _____

DATE : _____

TECHNICIAN NAME :_____

TECHNICIAN SIGNATURE : _____DATE : _____