Donna Johnston, MD: Consent for Platelet Rich Plasma (PRP)

Patient's name: __________________________________ Date of procedure:____________

PLATELET RICH PLASMA (PRP): is an injection treatment whereby a person's own blood is used. Your blood is drawn in standard fashion. The blood is spun down in a special centrifuge to separate its components (red blood cells, platelet rich plasma, and plasma). The platelet rich plasma is injected into the scalp to stimulate the hair follicles to grow hair.

Contraindications: PRP used for aesthetic procedures is safe for most adults but should not be used if you have:

1. Acute or chronic infections
2. Skin diseases (lupus, porphyria, allergies)
3. Cancer or undergoing chemotherapy
4. Severe metabolic and systemic disorders
5. Abnormal platelet function
6. Chronic liver pathology
7. Anti-coagulation therapy
8. Systemic use of corticosteroids within two weeks of the procedure
9. Pregnant or breastfeeding

Risks and Complications:

I have been informed that some of the side effects of platelet rich plasma include:

_____ pain or itching at the injection site

_____Bleeding, bruising, swelling, and/or infection at the site where blood was drawn and/or at the site of the PRP injections in the scalp.

_____Short lasting pinkness/redness(flushing) of the skin

_____ Injury to a nerve and/or muscle

_____Nausea/vomiting

_____ dizziness or fainting

_____Temporary blood sugar increase

_____Allergy

_____ A temporary headache

_____Redness in the scalp for 2-4 days

_____Reaction to topical numbing medicine (if it is used) can occur.

_____Hair loss (temporary) in the existing hair. This is often termed “shock loss”

_____Injury to nerve during blood draw (very rare)

I understand the risks and benefits of PRP and all of my questions have been answered._____(initial)

I understand the intention is to improve my health and/or appearance but that there are no guarantees with any cosmetic procedure. I am aware that the practice of medicine is not an exact science and that knowledgeable physicians sometimes disagree as to the best methods of treatment to achieve desired results. _____ (initial)

I am aware this is not covered by my insurance and I know I am responsible for payment of these services with no fee reimbursement regardless of procedural results. I understand the fee paid is for the procdure and not for an expected result. I understand the payment is due the day of my procedure.____ (initial)

I have read and signed this consent while I was NOT under the influence of medications that might alter my mental capacity to understand its contents. _____(initial).

Patient’s name:___________________________________

Patient’s signature:________________________________ Date:___________

Witness/staff signature:____________________________ Date:___________

Physician/provider: -- Date:___________