PATIENT INFORMATION & CONSENT

Description of treatment:

This treatment involves the collection of your blood (approximately 11 mL – 22 mL), then the blood is spun down using a centrifuge to separate out the plasma and platelet portion using the separator gel as a special filter. The platelet-rich plasma (PRP) portion of your blood is then used at the point of care. The product injected is 100% your own blood by product (autologous). ***If you have any questions, please do not hesitate to ask your physician or nurse.***

Mr / Mrs / Ms / other:_____ First name:_____ Surname: _____

Address: _____

_____

_____

Tel home: _____ Tel work:_____ Mobile: _____

Emergency contact name:_____ Contact number: _____

Relationship to person: _____

Email:_____ Date of birth: _____Occupation: _____

Pre-testing done, if any? _____

Blood tests: Full blood count Yes / No Pain relief option chosen: _____

Topical applied at:_____Removed at: _____ Amount of plasma made:_____ml

Area(s) to be treated today:_____

Previous surgical and non-surgical facial placement notes: _____

_____

Cosmetic procedures: _____

_____

_____

_____

Contraindications:

You should not have PRP treatment done if you have any of the following conditions:

Skin conditions and diseases including: Facial cancer, existing or uncured. This includes SCC, BCC and melanoma, systemic cancer, chemotherapy. Steroid therapy, dermatological diseases affecting the face (i.e. Porphyria), communicable diseases, blood disorders and platelet abnormalities, anticoagulation therapy (i.e.: Warfarin)

Comments: _____

_____

If you are unsure about any of above mentioned conditions, please ask!

Have you ever been told that you suffer from or suspect you suffer from: Platelet dysfunction syndrome, critical thrombocytopenia, auto-immune disease, Hypofibrinogenemia, haemodynamic instability, sepsis, chronic liver disease, hepatitis or any acute or chronic infections?

YES / NO (circle one)

If yes, please state:

_____

_____

PATIENT INFORMATION & CONSENT

Are you currently taking any of the following medications: Aspirin, anti-inflammatory medication such as Nurofen, Votaren, Diclofenac or Naproxen etc.? St John's Wort, Garlic, Vitamin E?

YES / NO (circle one)

If yes, please state which one(s) and last date taken:

_____

_____

Are you currently taking or have you recently taken (within 14 days) Vitamin E, fish oil or other supplements that could have a thinning effect on your blood?

YES / NO (circle one)

If yes, please state:

_____

_____

SIDE EFFECTS: You will likely experience mild to moderate swelling of the treated area, this will last for about 12- 24 hours; ice or cold compresses can be applied to reduce swelling if required. You may notice a tingling sensation while the cells are being activated. In rare cases, skin infection or reaction may occur, which is easily treated with an antibiotic or inflammatory.

Client Consent

I understand that due to the natural variation in quality of platelet-rich plasma, results will vary between individuals. I understand that although I may notice a change after my first treatment; I may require multiple sessions to obtain my desired outcome.

The procedure and side effects have been explained to me including alternative methods; as have the advantages and disadvantages.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. I am aware that the PRP treatment is not permanent as natural degradation will occur over time.

I authorize _____ to perform this procedure with PRP (platelet-rich plasma) for rejuvenation.

This consent form will be valid for up to 6 applications of PRP, after which time I may be asked to complete a new form. I state that I have read (or it has been read to me), I understand this consent and I understand the information contained in it.

I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled in prior to my signature.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

When completing the medical questionnaire, I have answered the personal medical history questions fully and to the best of my ability.

Name _____

Signature _____ Date _____

Clinic Name: _____