

**PRP (Platelet Rich Plasma) / PRF THERAPY CONSENT & RECORD FORM**

Patient details

Name:
Address:
Post code:
Email:
Tel/Mobile:
Date of birth:

Please ensure you understand the potential complications and personal requirements of the procedure indicated below by answering the following questions. If you are unsure of any details, please discuss with the practitioner treating you.

	Yes	No
Are you pregnant or is there any possibility that you are pregnant?		
Are you breastfeeding?		
Do you suffer from any illnesses e.g. diabetes, angina, epilepsy, hepatitis, auto immune disease? If Yes, please specify.		
Do you suffer from AIDS or viral hepatitis? If yes, please specify.		
Do you have, or have you had, any form of skin cancer? If yes, please specify.		
Are you allergic to topical (applied to skin) anaesthetics?		
Do you suffer from any known allergies? If Yes, please specify.		
Do you have a history of anaphylactic shock (severe allergic reactions)?		
Do you suffer from keloid or hypertrophic scars?		
Have you been diagnosed with any skin conditions? If yes, please specify.		
Are you taking / receiving steroids, chemotherapy or radiotherapy? If yes, please specify.		
Have you taken oral retinoids (Roaccutane) in the past 6 months?		
Have you taken Aspirin, Warfarin, other anti-coagulant treatments or any other medication or dietary supplements that can affect bleeding time within the last 10 days?		
Are you taking any other medication, including the contraceptive pill? If Yes, please specify.		
Have you used any <b>topical</b> retinoid's / Vitamin A products in the last 3 days? If yes, please specify.		
Have you used any exfoliants, alpha hydroxy (AHAs) or beta hydroxy (BHAs) acids, hydroquinone, benzoyl peroxide products within the last 3 days? If yes, please specify.		
Do you have a history of herpes simplex (cold sores) or other skin infections?		
Have you undergone a laser resurfacing laser hair removal or dermabrasion in the last 7 days?		
Have you had a skin peel in the last 6 weeks? If yes, please specify.		
Have you been exposed to excessive sun, electrolysis, depilatory creams, or waxing in the last 5-7 days? If yes, please specify.		
Have you previously received any aesthetic treatments (eg Botox dermal fillers, facial fat transfer etc.)? If yes, please specify which treatment, and when your last treatment was.		

	Yes	No
Have you previously experienced any reactions from aesthetic treatments (e.g Botox dermal fillers, peels, laser, dermabrasion, facial fat transfer etc.)? If yes, please specify		
Have you ever had treatment of permanent filler injections? If yes, please specify		
Do you have any tattoos or semi-permanent makeup in the area of treatment? If yes, please specify?		
Do you smoke? If yes, how many/day?		
How would you describe your skin? (please circle) Dry, oily, acne, acne prone, combination, pigmented.		
What skincare products are you currently using? (Retinoids, brands, moisturisers, makeup etc)		
What are your skin concerns? (please circle) Acne, acne scarring, dryness, dull/grey, hyperpigmentation, fine lines & wrinkles, oil control, rosacea/redness, scarring, sun damage, thread veins.		
What area of the skin do you want to treat? (please circle) Face, body, hands, scalp.		
What are you hoping to achieve from this treatment?		

The procedure is typically used for skin rejuvenation and hair loss. PRP treatment uses either a dermaroller/electronic microinjector, cannula (large blunt type needle), or needle to deliver blood plasma directly into the skin. It is moderately uncomfortable. A numbing cream can be applied to the skin approximately 30-45 minutes before treatment begins.

After the PRP procedure, the skin may experience:

- Redness & flushing - should decrease over a 24-hour period
- Swelling & pain – should decrease within 3-4 days
- Tenderness, stinging, itching
- Some pinpoint bleeding
- Tightness

These sensations will usually typically resolve within hours and many people are able to return to their normal activities the same or next day. Some people may react differently and may experience these reactions for longer. However, they gradually subside over the next 3-4 days as the skin returns to normal.

There is a small risk of side effects causing the skin to turn very red, blister, swell, peel and later scab and crust. In severe cases infection and ulceration may result, although this is not expected to occur due to the sterility of the needles/cannula used and the minimally invasive nature of the them.

PRP therapy procedure may cause areas of bruising although this would not normally be expected to occur, the eye contour being the area at most risk. Any such bruising will be temporary. If you are taking any medication or dietary supplements that can affect platelet function and bleeding time, the severity and period of bruising can be extended, also the presence of petechiae (small red or purple spots beneath the skin) may be observed.

#### PRP Post Treatment Advice

- Avoid products other than what has been recommended by my practitioner as others than the recommended may interfere with treatment.
- It is recommended that the use of soaps, other than those recommended by your practitioner, on the treated skin area is restricted until the skin normalises and where possible warm / tepid water and / or gentle skin cleansers are used for cleansing. Do not scrub. Pat to dry only.
- Refrain from touching the skin with your hands until the pores have had chance to close.
- Makeup can be applied once the skin has settled – usually the next day.
- The skin may flake after a couple of days - refrain from touching or pulling at any loose peeling skin as this can cause an uneven result in pigmentation.
- Avoid, electrolysis, depilatory creams, waxing, and laser hair removal for a minimum of 1 week after treatment or until the skin normalises.
- Avoid intensive sun light, saunas, sunbed, and steam bath for at least 1 week.
- Use adequate sunscreen protection for at least a week after treatment.
- Report any concerns to my practitioner as soon as possible.

Consent

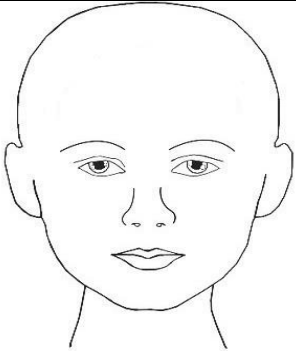
I understand this treatment is an elective medical-cosmetic treatment and hereby acknowledge the following:

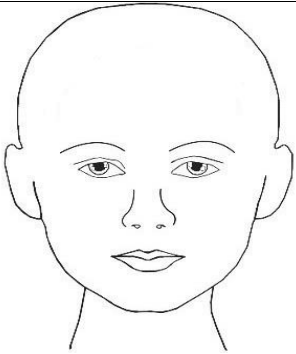
	Yes	No
I confirm I do not suffer from oncological, autoimmune and liver diseases.		
I have not been treated with anticoagulants (blood thinners) and have not taken Aspirin in the last 10 days.		
I confirm that to the best of my knowledge the health history that I have supplied is correct and that there is no other medical information I need to disclose.		
I further understand that withholding any medical information may be detrimental to my health and safety during the treatment in which I agree to undertake.		
I understand that if there is any change in my medical history, it is my responsibility to advise the practitioner before further treatments are carried out.		
I have been informed in detail and understand possible risks, conditions, reactions, side effects associated with the treatment and I understand that the development of any reactions/side effect must be reported to the practitioner as soon as possible.		
I understand I may require a series of treatments to achieve the maximum cosmetic result.		
I certify that I will make available where possible any follow-up visits as my practitioner advises if required - approximately 2-6 weeks.		
The effects of treatment will vary with some patients than with others and I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no written, implied, or verbal guarantee that the anticipated results will be achieved.		
I have understood and agree to follow above post treatment advice given in the form of <b>a leaflet</b> in the knowledge that deviation can cause a disappointing result and, in some instances, can pre-dispose me to side effects and reactions to treatments.		
The treatment has been explained to me by the practitioner and I am aware that my own blood is used to carry out the procedure and I confirm that I agree to the PRP procedure and I have had the opportunity to ask questions and that these have been answered to my satisfaction and I confirm that I have been allowed sufficient time to make a carefully considered decision.		
I understand that pre and post-treatment photographs will be taken and that these will be used for assessment reasons. I can confirm these images are taken with my knowledge and I consent to them being placed in my file.		
I consent to photographs being used for educational, training, teaching, and lectures.		
I consent to photographs being used for:		
Website		
Facebook		
Instagram		
Twitter		

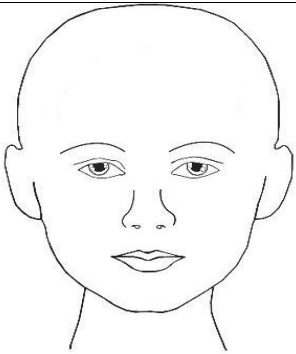
Treatment No.	Date	Time	Print Name	Signature I have read the above consent
1				
2				
3				

OFFICE USE ONLY

Client Name:

Date:	Time:	Photograph taken YES / NO	Topical anaesthesia:	Cleanser:
Sterile Pack Lot No: Expiry Date:		Needle Lot No: Expiry Date:		Product Lot No: Expiry Date:
Area:		Indication:		Method (circle): Microneedling - Cannula - Needle
 <p>Notes:</p> <p>Administered by:</p>				

Date:	Time:	Photograph taken YES / NO	Topical anaesthesia:	Cleanser:
Sterile Pack Lot No: Expiry Date:		Needle Lot No: Expiry Date:		Product Lot No: Expiry Date:
Area:		Indication:		Method (circle): Microneedling - Cannula - Needle
 <p>Notes:</p> <p>Administered by:</p>				

Date:	Time:	Photograph taken YES / NO	Topical anaesthesia:	Cleanser:
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Area:		Indication:		Method (circle): Microneedling - Cannula - Needle
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