Skin Deep REJUVENATION CLINIC

Skin Needling consent form

Title____________ First Name__________________________ Surname______________________________

Address ____

Occupation ___________________________ Email ____

Mobile ______________________________ Other Contact number _____________________________________

Date of Birth __________________________ Ethnic Background ____

Family Doctor Name & Contact No: ____

Emergency Contact Name & Number ___________________________ Relationship ____________________________

How did you hear about our salon? ____

Do you have any current or chronic medical illnesses? ☐ Yes ☐ No Details _________________________________

Are you under a doctor's care? ☐ Yes ☐ No Details _________________________________

Are you taking any photosensitising medication? ☐ Yes ☐ No Details _________________________________

(i.e. Anti-depressants, ST Johns wart etc?)

Do you have permanent makeup , implants or Tattoos? ☐ Yes ☐ No Details _________________________________

Anti-wrinkle injection, dermal fillers or chemical peels (within 12mths) ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If so, how many per day? ____

Are you on HRT? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If yes, please list ____

Client Treatment Report

Date of treatment	Clinician name & Signature	Treatment Details	Settings Used	Amount Paid	Payment Details	Comments

Home Care Regime

AM	PM
Cleanser	Cleanser
Eyes	Eyes
Serum	Serum
Moisturizer	Moisturizer
SPF	SPF

Medical Informed Consent

I Consent and authorise Skin Deep Rejuvenation Clinic to Skin Needling on me. I understand the following points and have had the opportunity to ask questions during my consultation.

Skin Needling consent form

In relation to Skin needling, I have been advised as follows:

1. Treatment is successful on most clients but my individual results cannot be guaranteed.
2. Most clients require 3 to 6 treatments to achieve the results
3. Darker skin type clients will require additional treatments.
4. No UV exposure for 24-48 hours, the use SPF 30+ sunscreen is mandatory
5. Not following the program regarding timing of treatments will reduce efficacy of my treatment

Risks associated with Skin Needling treatment

Even though the risk of complication is extremely low, the following can occur: **(Please Tick & Initial)**

☐Pigment changes (light or dark spots on the skin) lasting 1-6months. Freckles may temporarily or permanently disappear in treated areas. Other potential risks include crusting, itching, pain, bruising, pimple-like bumps, dry skin, hypopigmentation (lightening of the skin), hyperpigmentation (darkening of the skin), blistering, burns, infection, scabbing, swelling, a very risk of scarring and a failure to achieve the desired results.

☐Allergic or delayed inflammatory reactions can develop. A test patch is performed to ascertain reaction of the skin

☐I consent to photographs taken to evaluate effectiveness. Photographs revealing my identity will not be used without consent.

☐I understand the sensation of skin needling treatment is sometime uncomfortable and feels like a prickly and mild sun burn sensation after treatment

☐I am 18years or over (otherwise parent or guardian to sign)

☐I will advise Skin Deep Rejuvenation Clinic of any changes that occur during my treatment that can increase potential risks or reduce efficacy

☐I also understand that there will be no refund for any performed services.

In relation to my initial and all subsequent treatments I advise that: (Please Tick & initial)

☐ I have not had unprotected sun exposure (including tanning beds and fake tan creams) in the last 4 weeks.

☐ I have not used mechanical epilation, waxed or tweezed.

☐ I have no history of seizures and I have disclosed all known allergies (eg Latex etc)

☐ I am not taking medications causing photosensitivity (prescriptions/non-prescription) eg. St Johns wart, anti-coagulants etc.

☐ I do not have a history of keloid & hypertrophic scar formation.

☐ I do not have active infections/Immunosuppression.

☐ I do not have open lesions in the areas to be treated.

☐ I do not have Herpes I or II – in the areas to be treated

☐ I have not used Tretinoin (Retin – A, Renova) within the last 2 weeks

☐ I have not had Laser Resurfacing within the last 6 months

☐ I have not had a Chemical Peel – within the last 4 weeks.

☐ I have not used Oral isotretinoin/Accutane – within the last 6 months.

☐ I have advised my clinician if I am a diabetic.

☐ I am not pregnant, do not have hormonal imbalances or taking and medication which may affect treatment outcomes.

☐ I have received the pre and post care information Sheet. I agree to adhere to all these recommendations.

☐ If my treatments related to facial hair reduction, I have been advised of the possibility of on-going long term maintenance.

☐ Cancellations : You need 24 hours notice to change your appointment otherwise a fee will be charged. No Shows, If you are on a package that appointment will be taken off your remaining appointments. Non package clients will be invoiced for appointment.

I have read all of the above and had all my questions satisfactorily answered. Note : Do not sign this form until you have read and understood all of the above.

Name in Full ____ Date ________________________________

Signature ____ Clinician (Witness) __________________________________

Treatment series

I certify that all the information given above is true and I have not had any of the following

- Sun Exposure in the last 4 weeks
- Change in medication
- Been under doctors care or supervision
- Any surgery
- Pregnancy /trying to be pregnant or breast feeding

- Treatment 1

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 2

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 3

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 4

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 5

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 6

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 7

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 8

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 9

Signature _________________________Date __________________________Clinician (witness)____________________

- Treatment 10

Signature _________________________Date __________________________Clinician (witness)____________________