Hydro-dermabrasion 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? _____
What method of hair removal do you currently use (if applicable tick below) _____
☐ Tweezing ☐ Depilatory Creams ☐ Shaving ☐ Emjoy ☐ Waxing ☐ Electrolysis ☐ Other _____
How Often? _____

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 makup , implants or Tattoos? ☐ Yes ☐ No Details _____
Botox, dermal fillers or chemical peels (within 12mths) ☐ Yes ☐ No ***Note : some products can react with IPL***
Do you smoke? ☐ Yes ☐ No If so, how many per day? _____
Do you have any allergies? ☐ Yes ☐ No If yes, please list _____

Lifestyle question-

How many hours do you sleep per night? _____

How often do you exercise? _____

On a scale from 1 (low) to 10 (high), how would you rate your stress level? _____

Medical questions

Please list all medications that you take regularly. Include hormones, vitamins, etc_____

Please check any health conditions which you have had or are now experiencing:_____

- Asthma
- Alcoholism
- Cancer
- Claustrophobia
- Epilepsy High/low blood pressure
- Anti wrinkle injections
- Diabetes
- Heart problems
- Hepatitis
- Hormonal disorders
- Hypoglycaemia
- Hysterectomy
- Recent illness
- Thrombosis
- Muscular condition
- Multiple sclerosis
- Metal implants screws
- Pregnancy/recently pregnant
- Recent surgery
- Lack of normal skin sensation
- Dermal fillers smoking
- Thyroid

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 perform Hydro dermabrasion on me. I understand the following points and have had the opportunity to ask questions during my consultation.

In relation to IPL hair reduction treatments, I have been advised as follows:

1. Treatment is successful on most clients but my individual results cannot be guaranteed.
2. Most clients require 6 to 10 treatments to achieve the results
3. Darker skin type clients will require additional treatments.
4. Exposure to UV Rays will compromise my treatment, therefore I will use SPF 30+ sunscreen.
5. Not following the program regarding timing of treatments will reduce efficacy of my treatment

Risks associated with Hydro dermabrasion 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.

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

☐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

- 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)_____