IN YOUR FACE ESTHETICS

PLASMA FIBROBLAST CONSULTATION RECORD

Fibroblast is a procedure that can only be performed by a qualified esthetician, using approved equipment to shrink the skin using a sterile disposable probe.

Before carrying out the treatment, you are required to complete and sign this consultation record, thus giving your absolute consent to treatment. Additionally, you will need to disclose your full medical history, which will determine whether you are a suitable candidate for the proposed treatment. If the esthetician does not believe you are suitable for the treatment, it will not be performed.

Your esthetician will discuss the procedure in full, including what it will involve, discuss the benefits, explain any risks, the healing process and advise upon any further treatment if/where necessary. You will then be provided with written aftercare information for you to keep and refer to during the subsequent healing process.

Contra-indications will be recorded on this consultation form, which will be used as a reference for future visits.

It is important you clearly mark any areas of this form you wish to have clarified or discuss further. *It is ultimately YOUR responsibility to ensure you understand in full the procedure and the expected outcomes before treatment commences.*

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED, ONLY when you are happy to proceed. Ensure all points below have been discussed with your esthetician. You are signing to state that you understand and accept these terms.

Terms of your treatment:

- You have chosen a cosmetic procedure that is not medically necessary.
- Fibroblast is an art process - not an exact science - and cannot guarantee an exact shrinkage result due to skin elasticity and individual healing process.
- You may be required to return for additional treatments before your overall procedure is deemed complete. The payment for any additional work, (if applicable), will be agreed prior to the treatment commencing. Depending upon area of treatment, additional treatments cannot be performed until after 4-8 weeks from date of initial treatment. This is in order to allow the initially treated area to heal fully.
- Your esthetician will use a treatment plan to record the areas you have chosen, topical anesthetic used, probe used, as well as pre- and post treatment photographs. This information will be held securely in your consultation record.
- The skin type of every client is different and the healing process may lead to some discoloration of the skin. (Microdermabrasion or skin rejuvenation) may be advised, after the healing process is complete.
- After each treatment some swelling or redness may occur. In some cases there may be extreme swelling. Your esthetician will give you appropriate advice to help reduce this risk. Throughout the treatment you may experience some discomfort, but your esthetician will reassure you throughout your treatment and endeavor to make you feel as comfortable as possible.
- Since the treatment includes small burns to the skin, you may experience the smell of charring. This is perfectly normal.
- You must adhere to the esthetician's aftercare advice given to you following your treatment. This is very important and will reduce the risk of post procedural infection upon leaving the clinic.
- You must let the treated area heal properly. Avoid picking, plucking or scratching as this will hinder the healing process and could make the treatment appear uneven thus requiring further work.
- Be aware that skin altering procedures such as plastic surgery, implants, injectables and weight gain may alter the fibroblast look

TO BE COMPLETED BY THE CLIENT:

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FULL NAME:

DATE OF BIRTH:

ADDRESS:

PHONE:

EMAIL:

OCCUPATION:

TREATMENT AREA:

PHOTOGRAPHIC CONSENT

I consent to photographs being taken BEFORE, DURING, and AFTER my procedure. I agree to these being stored with my case file and used for promotional purposes.

CLIENT SIGNATURE:_____

PATCH TEST/WAIVER: (Please circle A or B)

(A) I understand that a skin test can determine whether I will experience a reaction to the products used by the specialist within 48 hours prior to treatment. However, I accept this will be inconclusive as to whether I will have an allergic reaction at any time in the future. I therefore waive my option to an allergy test and wish to proceed with treatment.

(B) I have undergone or been offered an allergy test prior to my initial treatment. I therefore release the specialist from liability related to any allergic reactions I may experience associated with either the application of pre-treatment cream or any other products used after the procedure, immediately or at a later date.

CLIENT SIGNATURE: _____

CONSENT

I understand that my esthetician will be in direct contact with me in relation to the fibroblast treatment. This treatment involves the use of a disposable probe. All other equipment is sterilized before use, all surfaces involved in the process are protected and gloves will be worn at all times by the esthetician during the treatment.

I hereby consent to receiving a fibroblast treatment. My esthetician has explained the terms and conditions of the treatment and I have fully understood these. I hereby give written consent to the esthetician to carry out the treatment of my choice as requested by me on this consent and treatment agreement.

Print Name: _____

Signature: _____

Date: _____

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MEDICAL FORM
(To be completed by the client)

Full Name: _____

Date of Birth: _____

Male or Female (please circle)

Have you received any skin tightening treatment before? YES / NO

(If Yes please answer the following questions:)

- How long ago was your treatment?
- What procedure did you receive?
- Where did you receive the treatment?
- Where you happy with the result? YES/NO
- If no, please explain the reasons why.

Are you over the age of 18? YES/NO

Are you pregnant or breastfeeding? YES/NO

Are you under the influence of alcohol or drugs? YES/NO

Are you in good health? YES/NO

CLIENT SIGNATURE:_____

MEDICAL CONDITIONS

Please answer YES or NO to the following questions. These details will then be discussed (in confidence) with your specialist.

- Do you feel fit and well enough to have a fibroblast procedure today? YES/NO
- Do you have any allergies or have you experienced any allergic reactions to medicine or products such as latex gloves, lidocaine, etc? YES/NO

If so please list:

- Are you currently taking any medication? YES/NO

If so please list:

- Do you have or are you planning to have any injectables, fillers or chemical peels in the near future? YES/NO
- Do you have any imminent holiday plans? (travel, sun exposure, photographs, etc) YES/NO
- Do you suffer from epilepsy? YES/NO
- Do you knowingly suffer from any infectious diseases? YES/NO

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- Do you suffer from a high or low blood pressure? YES/NO
- Do you suffer from diabetes? YES/NO
- Do you have any respiratory problems? YES/NO
- Do you suffer from, or have any problems with scars healing? YES/NO
- Do you suffer from dizziness or fainting attacks? YES/NO
- Do you suffer from HIV/AIDS? YES/NO
- Do you suffer from heart problems? YES/NO
- Do you suffer from Hepatitis? YES/NO
- Do you suffer with any Lymphatic problems? YES/NO
- Do you suffer from Hemophilia? YES/NO
- Do you suffer from skin problems (i.e. Eczema, Psoriasis)? YES/NO
- Do you suffer from Keloid scarring? YES/NO

If you suffer from any of the above it is important that you notify your esthetician who can take the necessary precaution to ensure you receive the best treatment to avoid any risks to your health.

- **I understand the importance of my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after the procedure. I understand that if there is any change in my medial history it is my responsibility to inform my esthetician.**

CLIENT SIGNATURE:_____

DATE: _____

- **I, the client, agree with all points listed and discussed, and wish to proceed as recorded. I participated fully in the decision for selected area or areas intended for my fibroblast treatment. I hereby agree to follow aftercare instructions.**

CLIENT SIGNATURE: _____

DATE: _____