



Treatment Form – PRP Therapy Vampire Facial

Title (Mr, Mrs, Miss, Ms.):

First Name: Surname.....

Address:.....

.....

Post Code: Date of Birth.....

Tel: Mobile:

E-Mail:

I am voluntarily consenting to a Platelet Rich Plasma procedure of the skin.

I understand that the procedure can result in an appearance enhancement and is typically used for skin rejuvenation and scar repair. The treatment uses a needling medical device that creates controlled micro-medical needle punctures of the skin surface.

I also understand that I may require a series of treatments normally with at least two-six weeks between procedures, to achieve the maximum cosmetic result.

I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure.

I understand the following:

Immediately after the procedure the skin will be red, resembling moderate sunburn, as the skin naturally heals the redness will resolve. The skin may remain red for three to four days after the treatment, although it is usual for it to subside within two days and many people are able to return to their normal activities the same or next day.

It is recommended that the use of soaps on the treated skin area is restricted until the redness subsides and where possible warm / tepid water and / or gentle skin cleansers are used for cleansing. If you are taking any medication or dietary supplements that can affect platelet function and bleeding time, the period of redness can be extended.

There is a small risk of infection of the treated skin area after the procedure, although this is not expected to occur due to the sterility of the medical device and the minimally invasive nature of the micro-medical needles. Needling procedures can 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.

There is a small risk that hyper-pigmentation of the skin can occur after the procedure, although this is not normally expected as the epidermis of the skin is not removed because of the procedure. Failure to follow the sun exposure and sun protection advice detailed below can increase this risk.

Please ensure you understand the potential complications and personal requirements of the Dermal Roller procedure indicated below and please acknowledge or answer the points and questions:

	YES	NO
Are you allergic to local anesthetics, do you have a history of anaphylactic shock (severe allergic reactions)?		
Do you consent to the use of a local anesthetic?		
Do you suffer from any known allergies? If yes, please specify on the next page of the is form.		
Have you taken oral retinoids (Roaccutane) in the last 12 months?		
Are you using topical retinoids/Vitamin A products?		
Do you have active acne with papules or pustules?		
Are you taking Aspirin, Warfarin, other anti-coagulant treatments or any other medication or dietary supplements such as Omega-3 that can affect platelet function and bleeding time?		
Do you have or have you had any form of skin cancer?		
Are you taking/receiving steroids, chemotherapy, radiotherapy?		
Are you taking any other medication? If Yes, please specify on the next page of this form.		
Do you suffer from any illness e.g. diabetes, angina, epilepsy, hepatitis, auto immune disease, HIV?		
Do you suffer from keloid or hypertrophic scars?		
Do you have a history of herpes simples (cold sores) or other skin infections?		
Have you undergone a laser resurfacing or skin peel in the last 6 weeks?		
Are you pregnant or is there any possibility that you are pregnant?		
Are you breastfeeding?		
Will you refrain from intensive sunlight exposure and/or artificial UV exposure for a period of at least 2 weeks?		
Will you use topical sun protection products with an SPF 30+ or higher and with stated UVA/UVB protection daily with regular applications for the same period?		

Additional comments:

Please do not book your appointment 2 weeks prior and 3 weeks post covid19 vaccine.

Do you, or any of your household have symptoms of Covid 19 Yes / No? If YES please do not attend your appointment.

I confirm that to the best of my knowledge that the information that I have supplied is correct and that there is no other medical information I need to disclose.

I understand that the practice of medicine and surgery is not an exact science and therefore that no guarantee can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no guarantee that the anticipated results will be achieved.

Patient/Client Signature: Date:

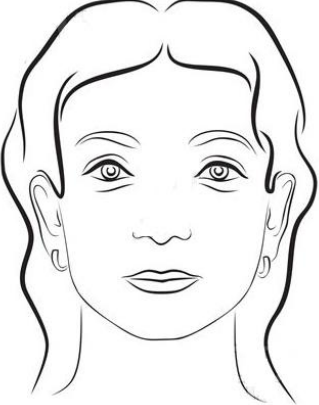
Practitioner Signature: Date:

Vaccine Y/N..... Date:.....

Dr's note required. Y/N

Date	I have read the consent	Signature

Treatment No.	Date	Needle Batch No.	Administered By

Treatment No.	Date	Needle Batch No.	Administered By

