Microchanneling Screening Form

BOLD RED items are hard contra-indication

Name: _____ Date: _____

Address: _____

City: _____ St: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Referred by: _____

Yes	No	Are you over 18 years of age?
Yes	No	Do you take aspirin or blood thinners regularly?
Yes	No	Have you had injectables in the past 30 days?
Yes	No	Have you taken any mood altering drugs in the past 8 hours?
Yes	No	Do you have a history of cold sores, herpes or fever blisters?
Yes	No	Are you sensitive to Latex?
Yes	No	Have you had a chemical or LASER peel? If so, when? _____
Yes	No	Do you have trouble healing?
Yes	No	**Are you currently undergoing radiation or chemotherapy?**
Yes	No	Are you currently using Retin-A, AHA, or other exfoliating skin care products?
Yes	No	Are you allergic to any metals?
Yes	No	Are you currently taking anti-inflammatory medications or steroids?
Yes	No	Are you allergic to any anesthetics, (any of the “caines”)?
Yes	No	Do you have a history of skin disease?
Yes	No	Do you have a history of skin sensitivity?
Yes	No	Are you currently taking vitamin A or E in any form?
Yes	No	**Are you pregnant or nursing?**
Yes	No	Are you currently being treated by a dermatologist?

Please circle any that apply to you:

Heart Condition	Hepatitis	HIV	Cold Sores
Hyper Pigment	Smoker	Compromised Immunity	**Accutane in last 6 Mos**
Allergic to Steel	**Diabetes (uncontrolled)**	**Chronic Skin Disease**	**Hemophilia**

Practitioner’s Name: _____

Practitioner’s Signature: _____

Microchanneling Consent Form

Patient name:_____ **Date:** _____

I authorize _____ to perform Microchanneling on my skin, and to apply topical preparations as determined necessary.

I understand that Microchanneling is non-ablative skin rejuvenation & involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as reddening, peeling, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection & scarring. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and that the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained, and that there are no refunds offered for lack of satisfactory results. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time. I also have completed a medical history checklist and been informed about what I must do and “not do” before, during and after the procedure.

I consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I furthermore indemnify the authorized person herein, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.

Signature: _____ Date: _____

Microchanneling Treatment Chart

Patient name:_____

Date	Areas	Needle Depths	# Passes

Recommendations for Future Treatment:

_____

☐ **Post care information given**

Notes:

_____

_____

Practitioner Sign Off:

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Microchanneling Post-Care

1. If you are given a mask, keep in on for at least 5 minutes.

2. If any Microchannel Delivery Solution roll-on remains, or if you are given a dilute solution at the end of treatment, apply every 5 – 10 minutes until gone.

3. Preferably no other products are applied until the following day, (although technically it is safe to apply products and makeup after about 2 hours).

4. Avoid exposure to pet dander and other irritants as best you can. You may experience a mild allergic reaction to pets and other things you typically to do not react to within the first 24 hours.

5. Your skin may feel hot and tight, like a mild sunburn. **Moisturize often**, and you may apply a cool damp wash-cloth as desired.

6. For your first treatment, (and treatments at .25mm in general) you can expect mild redness and swelling, and a tight, warm sensation for between 4 & 24 hours.

7. Later treatments, or those with longer needle lengths may produce redness and swelling along with tiny flecks of redness for between 4 & 72 hours. (These are easily covered with a quality mineral makeup).

8. Mild skin sloughing may occur for a few days after treatment.

9. Mild acne and milia can occur in **rare** cases. Don't pick and they'll go away in a few days.

10. Trans Epidermal Water Loss is a common temporary side effect and could leave you feeling dry through the first week. Keep the recommended moisturizer (preferably Oxygenetix) with you during the day and apply as frequently as necessary to avoid a dry sensation. The more you moisturize the better your results will be.

11. Beginning the following morning; apply the Cellular Renewal Serum and Healing Accelerator to enhance results. (Cleanse and apply 1-3 pumps). Apply daily, morning and evening.

12. Return for a follow up treatment in about a month or as recommended

If prolonged irritation occurs, please **email or call** our office.

Practitioner Name: _____

Practitioner Phone #: _____

Practitioner Email: _____