



## CONSULTATION RECORD

Plasmalift is a procedure that can only be performed by a specifically trained and qualified specialist. Using approved equipment to shrink the skin using a sterile disposable probe. The specialist is also fully insured.

Before carrying out the session, 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 specialist does not think you are suitable for the treatment, this will not be carried out.

Your specialist 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 specialist. 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.
- PlasmaLift 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 sessions before your overall procedure is deemed complete. The payment for any additional work, (if applicable), will be agreed prior to the session commencing. Depending upon area of treatment, additional sessions, cannot be performed until after 4-8 weeks from date of initial session. This is in order to allow the initially treated area to heal fully.

- Your specialist will use a treatment plan to record the areas you have chosen, anaesthetic 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 discolouration of the skin. (Microdermabrasion or skin rejuvenation) may be advised, after the healing process is complete.
- After each session some swelling or redness may occur. In some cases there may be extreme swelling. Your specialist will give you appropriate advice to help reduce this risk. Throughout the session you may experience some discomfort, but your specialist will reassure you throughout and endeavour to make you feel comfortable.
- 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 specialist'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 knocking 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, injectable's and weight gain may alter the PlasmaLift treatment look.

**TO BE COMPLETED BY THE CLIENT:**

<b>FULL NAME:</b>	<b>DATE OF BIRTH (DD/MM/YY):</b>
<b>ADDRESS:</b>	<b>TELEPHONE:</b>
<b>POST CODE:</b>	<b>MOBILE:</b>
<b>OCCUPATION:</b>	<b>EMAIL:</b>
<b>TREATMENT AREA:</b>	<b>PACKAGE:</b>
	<b>PRICE AGREED:</b>

**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 only with my written consent for promotional purposes.

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

**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 waiver 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.

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

**CONSENT**

I understand that my specialist will be in direct contact with me in relation to the Plasma 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 specialist during the treatment.

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

<b>Print Name:</b>	<b>SPECIALISTS SIGNATURE:</b>
<b>Signature:</b>	<b>DATE:</b>

**MEDICAL FORM (To be completed by the client)**

<b>Full Name:</b>
<b>Date of Birth (dd/mm/yy):</b>
<b>Male or Female (please circle)</b>
<b>Have you received any skin tightening treatment before?</b> <b>YES / NO</b> If Yes please answer the following questions:
<b>How long ago was your treatment?</b>
<b>What procedure did you receive?</b>
<b>At what clinic did you receive the treatment?</b>
<b>Where you happy with the result? YES/NO</b>  <b>If no, please explain the reasons why.</b>
<b>Are you over the age of 18?</b>
<b>Are you pregnant?</b>
<b>Are you under the influence of alcohol or drugs?</b>
<b>Are you in good health?</b>

Please answer <b>YES</b> or <b>NO</b> to the following questions. These details will then be discussed (in confidence) with your specialist.	<b>YES</b>	<b>NO</b>
Do you feel fit and well enough to have a PlasmaLift procedure today?		
Do you have any allergies or have you experienced any allergic reactions to medicine or products such as latex gloves, plaster etc? If so please list:		
Are you currently taking any medication? If so please list:		

Do you have or are you planning to have any injectables, fillers or chemical peels in the near future?		
Do you have any imminent holiday plans?		
Do you suffer from epilepsy?		
Do you knowingly suffer from any infectious diseases?		
Do you suffer from a high or low blood pressure?		
Do you suffer from diabetes?		
Do you have any respiratory problems?		
Do you suffer from, or have any problems with scars healing?		
Do you suffer from dizziness or fainting attacks?		
Do you suffer from HIV/AIDS?		
Do you suffer from heart problems?		
Do you suffer from Hepatitis?		
Do you suffer with any Lymphatic problems		
Do you suffer from Haemophilia?		
Do you suffer from skin problems (i.e. Eczema, Psoriasis)?		
Do you have an allergy to penicillin?		
Do you suffer from Keloid scarring?		

**MEDICAL CONDITIONS**

If you suffer from any of the above it is important that you notify your specialist 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 specialist.

**CLIENT SIGNATURE:** \_\_\_\_\_

**SPECIALIST SIGNATURE:** \_\_\_\_\_

**Notes to discuss:**

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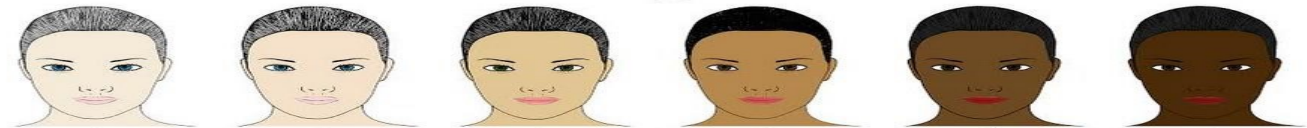


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## PLASMALIFT TREATMENT PLAN

This part of the consultation record is to be completed by the specialist in order to record important elements of the treatment. This form must be kept with the clients Medical and Consent forms.

**PLEASE USE THIS FORM TO RECORD THE TREATMENT OF ONE AREA ONLY.** All other treatments must be recorded on separate treatment plan forms.

<b>Treatment area(s) being completed:</b>						
<b>Number of treatments recommended:</b>						
<b>Treatment number: Please circle. (only 4 treatments per 1 area)</b>						
1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> 4 <sup>th</sup>						
<b>Indicate which scale:</b>						
<i>Skin Types</i>						
						
<table border="0" style="width: 100%; text-align: center;"><tr><td><b>1</b> <i>Very Fair</i> always burns cannot tan</td><td><b>2</b> <i>Fair</i> usually burns sometimes tans</td><td><b>3</b> <i>Medium</i> sometimes burns usually tans</td><td><b>4</b> <i>Olive</i> rarely burns always tans</td><td><b>5</b> <i>Brown</i> never burns always tans</td><td><b>6</b> <i>Black</i> never burns always tans</td></tr></table>	<b>1</b> <i>Very Fair</i> always burns cannot tan	<b>2</b> <i>Fair</i> usually burns sometimes tans	<b>3</b> <i>Medium</i> sometimes burns usually tans	<b>4</b> <i>Olive</i> rarely burns always tans	<b>5</b> <i>Brown</i> never burns always tans	<b>6</b> <i>Black</i> never burns always tans
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<b>For first visit only: Following consultation with your client, what is the agreed treatment and how many visits will it take to achieve?</b>						
<b>What is the predicted outcome and recommendations?</b>						

**For 2nd and subsequent visits: CLIENT MUST COMPLETE A RECONSENT FORM .**

Were your clients expectations met?

Did the area heal as described?

What is the agreed objective for today's procedure?

What is the predicted outcome and recommendations?

Describe the treatment area including a description of the appearance of the skin:

**CLIENT SIGNATURE:** \_\_\_\_\_ **SPECIALIST**

**SIGNATURE:** \_\_\_\_\_

#### Treatment Agreement

I, the specialist, confirm I have checked all paperwork including consent forms and medical history, I have discussed all procedure points with my client and they understand all elements of the Plasma soft surgery treatment. Aftercare advice has been presented to the client.

Specialist signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### **Please ask your client to read, understand and sign the following prior to treatment:**

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 Plasma soft surgery treatment. I hereby agree to follow after advice.

Client signature: \_\_\_\_\_

Date: \_\_\_\_\_

Recorded Documentation

Treatment area(s):	Any other treatments on this day:
Anaesthetic used:	Lot / Expiry:
Photographic Evidence:	Fitzpatrick scale:
Tolerance Level(1 lowest 10 highest):	Were any other people present?

Notes: Comments made by the client and/or to the client after the procedure and information relating to further treatments required.

**To be completed by the client at the end of the procedure:**

My procedure has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns with my specialist.

I fully understand my aftercare instructions and have my aftercare advice sheet.

**CLIENT SIGNATURE:** \_\_\_\_\_

**SPECIALIST SIGNATURE:** \_\_\_\_\_