DERMA DESIGN

81 Beacon Street - Lichfield - WS13 7AS - 07539 553385

MEDICAL CONSENT FORM

Date of treatment ...../...../..... Technician .....

Derma Design will not perform any procedure on anyone under the age of 18 or under the influence of alcohol or illegal drugs. Proof of age may be requested.

TO BE FILLED IN BY THE CLIENT (BLACK INK ONLY PLEASE)

Clients name.....

Address.....

.....

Postcode ..... Contact Number.....

Emergency contact .....

Treatment today.....

I absolutely understand micro pigmentation is an art process and not an exact science and that every client heals differently. I understand that this is an elective procedure that is not medically necessary and is a multi treatment process.

Please initial.....

I absolutely understand that I am entering into a multi treatment contract until my procedure is deemed complete and that I agree to pay all treatment monies up front, I agree that if I decide not to return for additional treatments that my monies will not be refunded to me. I agree I have up to 3 months to return for additional treatments needed and that I will incur a charge after that time.

Please initial.....

Lip procedures only, it has been explained that should I suffer cold sores that I need to obtain a course of zovirax (or anti-viral medication) from my GP to reduce the risk of an outbreak. I accept the risk of cold sore outbreak when having tattooing within the lip area

Please initial.....

I have undergone or been offered an allergy test prior to my treatment and hereby release the technician from any liability related to any allergic reaction or secondary reaction to applied pigments or other products used during or after the procedure or at a later date. Pigments are mainly composed of iron oxide, alcohol, glycerol and water.

Please initial.....

All needles and machine parts used are individually wrapped, sterile and disposed of after each treatment. I accept that whilst in treatment room all universal precautions are taken but my risk of infection begins the moment I leave the centre.

Please initial.....

I confirm I will agree all colours and shape prior to any work commencing, and that the technician will keep a log of colours etc. chosen to assist further visits. I agree to before, drawn and after photographs being taken. These photographs will be stored on my file and not used for any other purpose unless I agree in writing.

Please initial.....

I accept that after the treatment the direct area treated may show signs of swelling, redness and in rare cases bruising. I accept some discomfort.

Please initial.....

I accept that colour chosen and applied may appear darker for up to 7 days after treatment then will start to lighten after, I accept that I need to return for additional applications and that if I don't return the makeup will fade faster in the skin and additional work will be charged for.

Please initial.....

I confirm I will strictly adhere to the aftercare instructions given to me and only apply aftercare products given to the treated area. I also accept that complications and rejection of pigment are possible if aftercare instructions are not followed and that should I get an infection post treatment that I will immediately visit my GP and accept that this is possibly due to the fact that I do not live in sterile conditions. If I have any concerns I will telephone my technician to discuss.

Please initial.....

I fully understand that colours will stay visible in the skin for 1 to 5 years and in some cases indefinitely. Also that light based colours fade faster than dark based colours and that colours change with time and the technician cannot guarantee the longevity of colour in the skin after each application this varies from person to person. I confirm and accept that should I use sun beds or frequent sun exposure, glycolic acids, aha products that this will fade my colours faster

Please initial……

I understand that laser treatments or further surgery may alter my micro pigmentation and I do not hold the technician responsible.

Please initial……

I understand that if I have an MRI or CAT scan micro pigmentation may tingle in the treated area this will not affect the treatment.

Please initial……

I understand that if I wish to change either the colour, thickness or shape after my first application of cosmetic tattooing that additional cost will be incurred as the area will need an additional treatment.

Please initial……

I confirm that I have not consumed alcohol within the last 24hrs.

Please initial……

Please note that if considering laser hair removal to inform the laser specialist that you have micro pigmentation as laser can drastically change the colour of the treated area if in direct contact. I hereby consent to the application of micro pigmentation. I have read and fully understand all the points listed in this procedure consent form. I accept full responsibility for any complications that may arise during or following the treatment as a direct result of failing to disclose relevant information regarding my health or current medications. I hereby give my written consent for a micro pigmentation procedure to be applied as requested by me on this consent and procedure agreement.

Signed ..... date...../...../.....

Please print name.....

Technicians name.....

Technician's signature.....

MEDICAL INFORMATION AND MEDICATION TO BE FILLED IN BY CLIENT:

Please circle YES/NO of all conditions that apply to you.

Pregnant yes/no	Cataracts surgery yes/no	Epilepsy yes/no
Breastfeeding yes/no	Cancer yes/no	Lupus yes/no
Eye disorder yes/no	Haemophilia yes/no	HIV yes/no
Diabetes yes/no	TB yes/no	Hyper pigmentation yes/no
Dry eye yes/no	Alopecia yes/no	Anaemia yes/no
Hepatitis yes/no	Asthma yes/no	Heart condition yes/no
Allergies to Dye yes/no	Thyroid condition yes/no	Keloid scarring yes/no
Skin disorder yes/no		

Are you currently under the care of a doctor or hospital specialist? YES NO (please circle)
If yes please give details

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Please list any medication you are taking including painkillers and or antibiotics.
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It has been explained to me by my technician that the medications listed above can have an impact on my treatment. Although the exact affect cannot be known, it has been explained that bleeding, bruising and longer healing times as well as possible poor retention of colour are all possible results from taking the above medications and I am happy to proceed.
Signed .....

Additional information

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.....
.....

Have you had micro pigmentation before? If yes please give details:

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PATCH TEST CONSENT I have decided to have an allergy test. I understand that I may have an allergic reaction to the micropigmentation products within 24 hours and that if I do I will not be able to have a micropigmentation procedure. I do understand that if no allergic reaction is evident within 24 hours that it is not construed that I may not have a reaction at a later date (secondary reaction). I affirm that I will release the technician from any liability to an allergic reaction should I wish to proceed with a micropigmentation procedure.

CLIENTS SIGNATURE: ..... DATE OF PATCH TEST: ……../……../.....

PATCH TEST WAIVER I understand that a skin test can determine if I will have a reaction within 24 hours to the products tested but that it is inconclusive regarding whether I will have an allergic reaction at any time in the future.

Therefore I waive my option to an allergy test and wish to proceed with a micropigmentaton procedure.

CLIENTS SIGNATURE: ..... DATE: ……./……./.....

TITANIUM DIOXIDE DISCLOSURE

Titanium dioxide is present as an ingredient in many pigment colours in small traces but present in larger quantities in lighter formulations and white pigment. Regardless of what is stated by the manufacturer on the label of the bottle no one can guarantee that white (an essential component used in many colours) is not going to be mixed in pigment. Therefore, by my signature on this form, I acknowledge that I understand that my decision to proceed with a micropigmentation procedure will prevent me having any future laser treatments in the area of my micropigmentation.

CLIENTS SIGNATURE: …… DATE: ……./……./.....

MAPPING AND PLANNING NOTES

FITZPATRICK SCALE :

CLIENT DESCRIBED SKIN TYPE:

DESIRED SHAPE

PIGMENT CHOICE

METHOD USED

PRICE £ TOP UP

I agree that if I request that the technician to change the shape, colour or thickness of the first application that another treatment will be needed and that I shall have to pay for this.

Signed ..... date...../...../.....

Please print name.....

Technician's signature.....

TREATMENT RECORD

lot expiry affix needle strip

Needle used

Anaesthetic 1)

2)

Pigment 1)

2)

I agree that I am happy with the treatment I have received today and the technician has applied the makeup as I have requested.

Signed ..... dated ……

I agree for picture of treated area to be shown on social media to assist other customers and to promote the skills of the technician.

Face YES/NO Area only YES/ NO

Signed ..... dated .....

I agree that I have been given written aftercare instructions. I confirm I have read and accepted aftercare conditions and will strictly adhere to them

Signed ..... dated .....