Treatment Form – Skin Boosters

Name:		**Email :**
DOB:	**ID Yes/No**	**Phone:**
Address:		**Social Media Images: Yes/No**

I am voluntarily consenting to the injection of Skin Boosters to change my appearance.

I understand the risks and conditions associated with a skin booster treatment and that it is an elective cosmetic procedure.

I acknowledge that the practice of aesthetic treatment is not an exact science and therefore that no guarantee can be given as to the results of the treatment outcome. 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

I acknowledge that whilst complications from this procedure are uncommon, they do sometimes occur. Side effects may (depending on the product used) include redness, swelling, bruising, discomfort, tenderness, swelling, and itchiness – these side effects may last from a few seconds up to a couple of weeks or more. I acknowledge that I have read and fully understand the list of potential side effects.

I am aware that some degree of swelling can be expected lasting about 2-3 days. Clients at risk of Cold sores are advised to take prophylactic aciclovir tablets and should apply topical cream, especially if threads are to be inserted around the lips. I will seek the advice of a pharmacist or GP before taking any medication.

I have provided the practitioner with all my medical history and/ or medication details. I fully accept any consequences of not providing full details and will not hold practitioner liable in respect of the same.

I am happy to proceed on the basis that existing facial asymmetry may not be completely rectified.

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 devices used.

I acknowledge receipt of the treatment advice sheet regarding dermal filler treatment and a copy of this agreement and have had a complete consultation regarding the same. I confirm that I have had sufficient opportunity to read the same and raise any queries resulting from the consultation itself or from reading the post treatment advice Sheet or this agreement. I further confirm that such queries have been satisfactorily answered.

I understand that I am undertaking this treatment knowing the full facts, side effects, treatment outcomes and complications and I will not hold the clinic responsible should any issues mentioned above occur.

I give full consent to the use of my before and after images for marketing purposes, providing all identifying features are covered and that there is no way to identify myself from the image. Images will be kept for 6 years and may be used in the event of a claim being brought against us. They will be stored on a password encrypted hard drive.

Under GDPR rule, I understand that I have full access to all data held on me. This data will be held by the clinic for no longer than 6 years for insurance purposes, after which, digital information will be deleted permanently, and paper documents will be destroyed. All information on myself is kept on password encrypted hard drives or locked in filing cabinets to which only selective staff members have access. None of my personal data will be sold or used for anything other than to provide the services of this clinic.

Signed By Patient	**Date:**
Signed by Practitioner	

Treatment Form – Skin Boosters

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

Are you allergic to local anaesthetics, do you have a history of anaphylactic shock (severe allergic reactions)? **YES / NO**

Do you consent to the use of a local anaesthetic? **YES / NO**

Do you suffer from any known allergies? If yes, please specify on the next page of the is form. **YES / NO**

Have you taken oral retinoids (Roaccutane) in the last 12 months? **YES / NO**

Are you using topical retinoids/Vitamin A products? **YES / NO**

Do you have active acne with papules or pustules? **YES / NO**

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? **YES / NO**

Do you have or have you had any form of skin cancer? **YES / NO**

Are you taking/receiving steroids, chemotherapy or radiotherapy? **YES / NO**

Are you taking any other medication? If Yes, please specify on the next page of this form. **YES / NO**

Do you suffer from any illness e.g. diabetes, angina, epilepsy, hepatitis, auto immune disease? **YES / NO**

Do you suffer from keloid or hypertrophic scars? **YES / NO**

Do you have a history of herpes simples (cold sores) or other skin infections? **YES / NO**

Have you undergone a laser resurfacing or skin peel in the last 6 weeks? **YES / NO**

Are you pregnant or is there any possibility that you are pregnant? **YES / NO**

Are you breastfeeding? **YES / NO**

Will you refrain from intensive sunlight exposure and/or artificial UV exposure for a period of at least 2 weeks? **YES / NO**

Will you use topical sun protection products with an SPF 30+ or higher and with stated UVA/UVB protection on a daily basis with regular applications for the same period? **YES / NO**

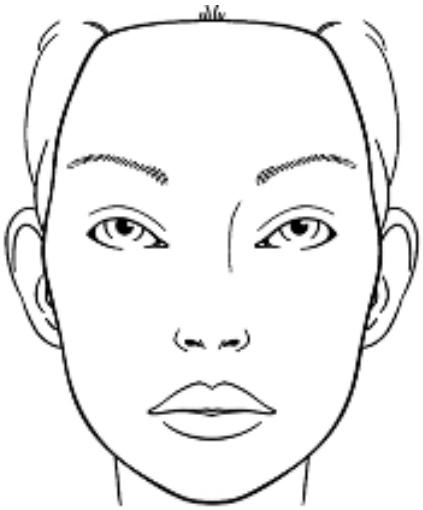
I confirm that to the best of my knowledge that the information that I have supplied is correct and that there is no other medical information I need to disclose. I understand that treatments and products is not an exact science and therefore that no guarantee can be given as to the results of the treatment 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.

Signed By Patient	**Date:**
Signed by Practitioner	

Treatment Record Card – Skin Boosters

Treatment Plan/Notes

Treatment Plan/Notes



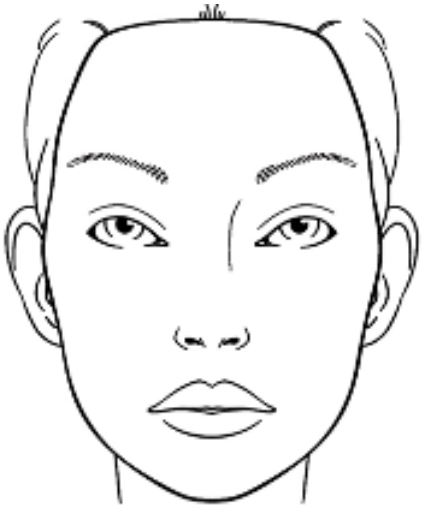
Treatment 1

Date:

Lot/Batch Num Sticker

I _____
(Client Name) have checked that there are no changes to my medical history since my last appointment.

Treatment Plan/Notes:



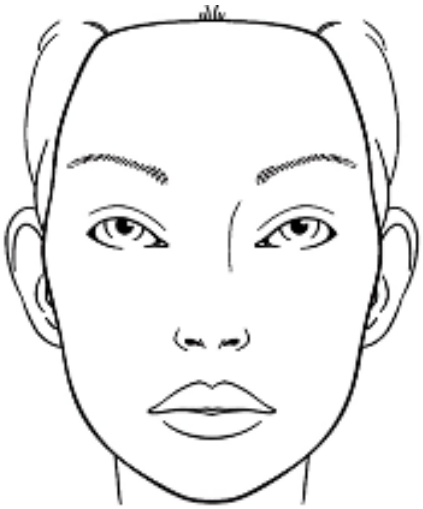
Treatment 2

Date:

Lot/Batch Num Sticker

I _____
(Client Name) have checked that there are no changes to my medical history since my last appointment.

Treatment Plan/Notes



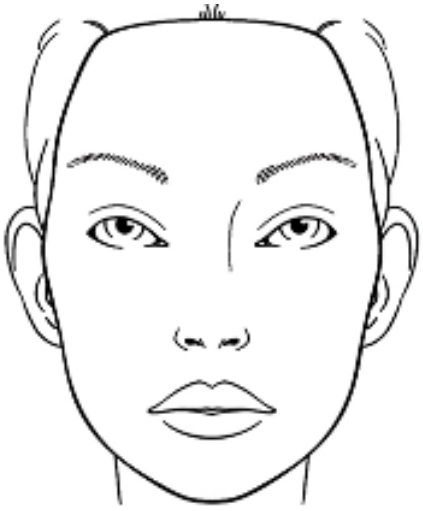
Treatment 3

Date:

Lot/Batch Num Sticker

I _____
(Client Name) have checked that there are no changes to my medical history since my last appointment.

Treatment Plan/Notes



Treatment 4

Date:

Lot/Batch Num Sticker

I _____
(Client Name) have checked that there are no changes to my medical history since my last appointment.