MICRO-NEEDLING CONSENT

Skin Needling

I confirm that I understand the risks and conditions associated with Skin Needling treatment and that it is an elective procedure.

The Skin Needling treatment is typically used for skin rejuvenation and improvement of scars. This treatment uses either a derma roller or micro needling medical device to create micro needle punctures that cause mild trauma to the skin's surface to stimulate the natural production of new collagen and elastin.

Possible Reactions from treatment include:

- Skin redness and flushing
- Tightness
- Itching
- Tenderness
- Stinging
- Swelling
- Some pinpoint bleeding.

Effects will usually resolve within hours and many people are able to return to their normal activities the same or next day.

Some people may react differently and may experience these reactions for longer. However, these reactions are temporary and typically resolve within 3-4 days as the skin returns to normal.

There is a small risk of side effects causing the skin to turn very red, blister, swell, peel and later scab and crust. In severe cases infection and ulceration may result, although this is not expected to occur due to the sterility of the derma roller / micro needling device and the minimally invasive nature of the micro-medical needles.

Skin Needle Therapy procedure may 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 hyperpigmentation 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 advice detailed below can increase this risk. Please continue to read the following:

- I confirm that I understand the risks and conditions associated with this treatment and that it is an elective medical cosmetic treatment
- I confirm that the medical history and medication details that I have supplied are complete and correct and that there is no other medical information I need to disclose.
- I understand that withholding any medical information may be detrimental to my health and safety during the treatment in which I agree to undertake.
- If there is any change in my medical history, it is my responsibility to advise the practitioner before further treatments are carried out.

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- I understand that there are certain contraindications that would preclude me from receiving treatment including an active bacterial, viral, fungal, or herpetic infection, raised moles or warts, active acne, rosacea, facial cancers, history of radiation therapy within the application area, a history of abnormal scarring, keloids, atrophic skin, autoimmune disorders, haemophiliac, diabetes, taking anticoagulants, pregnant or breastfeeding.

- I confirm that I understand the risks and conditions associated with the treatment. These have been fully explained to me and I have had the opportunity to ask any questions and these have been answered to my satisfaction. Development of any reactions must be reported to the practitioner as soon as possible.

- I accept and understand that there are no written, implied, or verbal guarantees as to the anticipated results of this treatment and that the effects of treatment will vary with some patients than with others and that the goal of this treatment is improvement, not perfection.

- I may require a series of treatments, normally with at least 3-6 weeks between procedures, to achieve the maximum cosmetic result.

- I have been given post treatment/ aftercare advice and I understand and agree to follow all the care instructions carefully to minimise the risk of side effects.

- I confirm that I have been allowed sufficient time to make a carefully considered decision.

- I consent to the taking of (pre and post-treatment) photographs to monitor treatment effects. Complete patient confidentiality will be maintained always.

- I understand that I am free to withdraw my consent at any time.

By my signature below, I acknowledge that I have read this Consent form and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with this Micro-needling treatment. I will immediately call the clinic or Practitioner as stated above with any questions, concerns, or signs of problems.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____