**FINESSE SKIN CLINIC**

**INFORMED CONSENT**

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| **Client Name**  |
| **Address**  |
| **Date of Birth** |
| **Treatment to be received** | **Date of treatment**  |
| **Cartridge Lot number:** | **Peel Lot Number:** |

**Client Statement:**

The information I have given within this document is, to the best of my knowledge correct. I have not withheld any known medical history or condition.

* I have read and understand the Consultation form and that I am over 18 years of age (or my parent or legal guardian is giving consent on my behalf) that I:
* I understand that the conditions listed in the consultation form and consent form can make me unsuitable for the required treatment. It is my responsibility to inform **FINESSE** if my circumstances change, on each and every visit for treatment.
* I have been informed that the person providing my treatment is a fully qualified beauty therapist or medical aesthetic practitioner and is suitably qualified to perform this procedure.
* I have been fully informed about the procedure I am to receive including the possible side effects and the aftercare procedures I must follow
* I freely assume responsibility for any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure.
* I consent to the taking of both before and after treatment photographs

**GP Disclaimer:**

I understand that the General Medical Council advise that General Practitioners are kept fully informed about all treatments undertaken by their patients. Either I have informed my General Practitioner, or in signing this form I am exercising my right not to inform my General Practitioner about the treatment I am about to undertake.

I have read and understood this consent form, all the above matters have been explained to me and my questions have been addressed and answered to my satisfaction.

**Client Signature ……………………………………………………………………**

**Practitioner name ………………………………………………Practitioner Signature …………………………………………**

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| **Photographs of your skin are taken before, during and after treatment to monitor and document progress.** |
| I hereby authorise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to take photographs of me before, during and after my treatment series.Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Pre-treatment consent and treatment information**

SKINPEN PRECISION – Post Treatment Advice

In order to achieve the best results possible, it is important that you read and understand the following instructions. Your practitioner will discuss the required post treatment protocols with you following treatment; these instructions must be adhered to as advised by your advanced aesthetic practitioner.

Post treatment the skin will be reddened, possibly a little ‘puffy’ and you may be aware of heat and a little tenderness. You will also experience skin tightness and the skin may also ‘flake’ in the first few days.

**Please initial those that apply:**

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| \_\_\_\_\_\_\_ I have provided accurate medical information and consultation details to my practitioner. |

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| \_\_\_\_\_\_\_\_ I am not pregnant or lactating. |

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| \_\_\_\_\_\_\_\_ I do not have any active Herpes simplex (cold sores). Prophylactic antiviral medication or topical antiviral cream may be used up to 5 days before treatment and up to 5 days after treatment. |

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| \_\_\_\_\_\_\_\_ I agree not to receive any of the following on the treatment area 2-4 week prior to treatment – Botox, injectable dermal filers or needling treatments.  |

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| \_\_\_\_\_\_\_\_ I agree not to receive any of the following on the treatment area 1-2 weeks prior to treatment – bleaching, electrolysis, depilation, facial treatments using AHA/BHA/Vitamin A, hair colouring, IPL/Laser for skin rejuvenation, IPL/Laser for hair removal, light therapy, microdermabrasion. |

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| \_\_\_\_\_\_\_\_ I agree to avoid the use of any prescribed topical medications i.e. Retin A, Salicylic Acid a minimum of 2 weeks prior to treatment. |

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| \_\_\_\_\_\_\_\_ I agree to avoid the use of active skin care 3-5 days prior to treatment. |

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| \_\_\_\_\_\_\_\_ I confirm that I have not used Isotretinoin in the past 6 months. |

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| \_\_\_\_\_\_\_\_ I agree to follow the treatment protocol advised by my practitioner for a minimum of 2 weeks prior to treatment. |

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| \_\_\_\_\_\_\_\_ I agree to avoid direct sun exposure. |

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| \_\_\_\_\_\_\_\_ I agree to apply a sunscreen daily (minimum SPF30). |

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| \_\_\_\_\_\_\_\_ I agree to avoid heat treatment immediately prior to treatment. |

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| \_\_\_\_\_\_\_\_ I agree to notify my practitioner of any concerns. |

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| \_\_\_\_\_\_\_\_ I understand that the following contra-actions may occur:

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| --- | --- | --- |
| * Bruising
 | * Itching/irritation
 | * Infection
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| * Histamine reaction
 | * Localised allergic reaction
 | * Urticaria
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| * Discomfort
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| \_\_\_\_\_\_\_ I understand that treatment results are varied and not guaranteed. |

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| \_\_\_\_\_\_\_ I have discussed my expectations and goals with my practitioner. |

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| \_\_\_\_\_\_\_ I have discussed the treatment limitations and possible complications with my practitioner. |

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| \_\_\_\_\_\_\_ I acknowledge the possibility of an adverse reaction to treatment and take sole responsibility for any medical care that may become necessary. I agree to immediately contact the practitioner performing the treatment of any adverse effects. |

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| \_\_\_\_\_\_\_ My practitioner has provided treatment information and answered all of the questions I have concerning this treatment. |

DO’s

* Do wash hands before touching the treated area
* Do use the remaining HG lift that your practitioner will have given to you and the day after treatment use the Rescue or Hydrating product to calm and soothe
* Do resume normal skincare after 24 hours, please note the skin will feel tight and extra thirsty
* Do avoid saunas, steam rooms etc. as excess heat can lead to discomfort, inflammation, irritation etc.
* Do avoid the use of exfoliating products until the skin is fully healed
* Do avoid waxing/hair removal in treatment area until the skin is fully healed
* Do keep out of the sun on the day of treatment and for the following 24 hours also
* Do use sunscreen factor 50 and keep out of direct sunlight to maximise long term results
* Do have a clean pillowcase on your bed and use clean towels
* Do increase water intake to at least 8 glasses per day

DON’Ts

* Don’t touch the skin unnecessarily immediately post treatment this will be important to avoid any post treatment infection.
* Don’t go swimming or in chlorinated water for 4-5 days post treatment and please
* Don’t engage in any heavy exercise sessions for 24-48 hours after treatment.
* Don’t the use of topical preparations/skincare products not designed for use following skin needling treatment for 24 hours.
* Don’t use of active skincare containing AHAs, BHAs and retinoids for 48 hours.
* Don’t pick or peel loose skin that may begin to flake following treatment
* Don’t shave or use any after-shave type products over the area that has been treated for 12-48 hours post treatment.
* Don’t have any other clinical treatments for 1-4 weeks post treatment. Speak to your practitioner for exact advice on how best to combine other treatments you may be having or may want to start having.
* Don’t restrict contact with pets, polluted atmospheres/environments to reduce the risk of infection whilst skin healing takes place

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| * **Treatment details**
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| **Anaesthetic used & verification that reactions were normal. Any adverse reactions to the anaesthetic must be detailed.****Brand used-** **How long was the product left on the skin -**  |
| **Needle lengths selected for:****Sensory Test: 0.25** | **Skin Reactions** |
| **cheeks** | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **chin** | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **jowls** | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **forehead** | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **upper lip** | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **nose** | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **eyes** | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **Other - Scars/ pigmentation**  | 0.25 0.5 0.75 1 1.5 | Erythema: Mild Moderate Severe Scattered EvenBlood Spots: Mild Moderate Severe Scattered Even |
| **Patient sensation/ discomfort levels during treatment 1-10** |
| **Patient heat levels post treatment 1-10** |
| **Patient tightness & tenderness levels post treatment 1-10** |
| **Post treatment feedback from the client**  |
| **Verification that the Patient is happy with the treatment, the skin post treatment and understands the importance of the aftercare discussed.**  |  |

I accept the results of the treatment performed today and I understand and agree to adhere to the above instructions. I agree to contact my advanced aesthetic practitioner with any additional questions I may have.

**Patient name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practitioner name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practitioner signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_