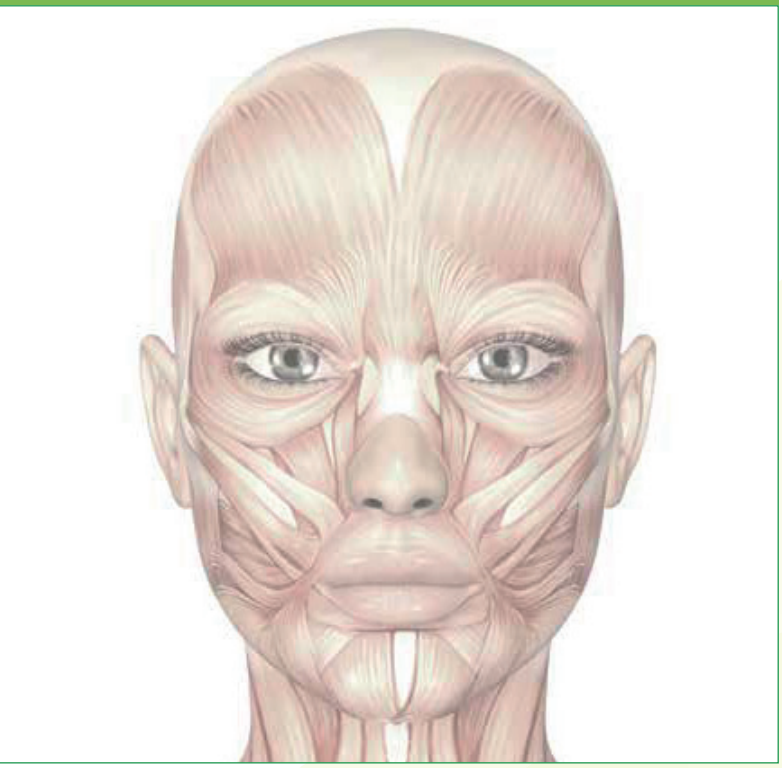
MEMBER OF THE AMERICAN AESTHETIC ASSOCIATION

skinessence
MEDICAL AESTHETIC CLINIC

INFORMED CONSENT FORM

Please request a copy of this consent form from your medical doctor



QUOTATION

Date (quote valid until): _____

Consultation (if applicable): _____

Procedure: _____

_____

_____

_____

_____

TOTAL (incl VAT): R

PRODUCT NAME AND LOT NUMBER:	
DATE:	NOTES:

PATIENT NAME: _____

AGE/YEAR OF BIRTH: _____

CONTACT NUMBERS: _____

EMAIL: _____

MEDICAL HISTORY

PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONNAIRE:

The answers to these questions are important for your health care and the appropriateness of the choices available to you. It will affect the information, instructions and warnings the doctor will provide you, and may affect the treatment choices available to you and in some cases it may be in your best interest not proceed with treatment. If you tick "YES" anywhere below, it is important that you provide further information in the space below:

Are you pregnant or breast feeding? Y ○ N ○

Do you have a history of severe allergy/anaphylaxis? Y ○ N ○

Have you had any dental treatments done in the past 4-6 weeks Y ○ N ○

Are you currently receiving any medical treatment or on any medication? If yes, please give more details Y ○ N ○

_____

_____

Have you previously received any aesthetic treatments? (e.g. laser, peels, dermabrasion, etc.) If yes, please give more details Y ○ N ○

_____

_____

Have you received any treatment with dermal fillers, including absorbable O 0 dermal fillers, semi-permanent dermal fillers or botulinum toxin? Y ○ N ○

_____

_____

Have you ever suffered from an auto-immune disease or a disease affecting the immune system (e.g. lupus, rheumatoid arthritis etc.)? Y ○ N ○

Do you have any (skin) infection or inflammatory problems (e.g. herpes, acne, etc.)? Y ○ N ○

Are you currently taking any steroids, aspirin or anticoagulant i.e. blood thinning agent (e.g. warfarin etc.)? Y ○ N ○

Do you suffer from acute rheumatic fever or recurrent sore throat? Y ○ N ○

Do you suffer from any allergies, in particular allergies to hyaluronic acid or amide type local anaesthetic (a type of anaesthetic that is in powdered form)? Y ○ N ○

Do you suffer from untreated epilepsy? Y ○ N ○

Do you tend to develop excess scar tissue? Y ○ N ○

Do you suffer from porphyria? Y ○ N ○

Do you suffer from cardiac (heart) disorders? Y ○ N ○

Have you suffered from any of the following? Y ○ N ○

If yes, please give details:

_____

_____

PRECARE
(BEFORE TREATMENT)

One week prior to your injection, we advise you to avoid using alcohol, garlic, lidocaine and aspirin, or any other non-steroidal anti-inflammatory medicines for pain, swelling and/or fever, such as medicines containing diclofenac, mefenamic acid, indometacin or ibuprofen - ask your doctor or pharmacist whether your medication includes any of these ingredients. Following these instructions will reduce the risk of bruising or bleeding at the point of injection.
If this is your first visit, you will need to provide your medical doctor with information on your medical history and any current problems, as well as details of any allergies you have or medications you are taking. There is no need for an allergy test, unless your medical practitioner or feels it's necessary.

POSTCARE
(AFTER TREATMENT)

Because the injectable gel is a relatively simple, non-surgical treatment, there is minimal recovery time. For the first 24 hours following treatment, you should avoid strenuous exercise, excessive sun or heat exposure, and alcoholic beverages, in order to help minimise the risk of temporary redness, swelling and/ or itching.
No treatment can halt the ageing process; you will require top-ups if you want to maintain the effect so ask your medical doctor when he/she would recommend rescheduling another appointment.

PLEASE CONSULT WITH YOUR MEDICAL DOCTOR IF FURTHER TREATMENT IS REQUIRED

INFORMED CONSENT

I CONFIRM I HAVE BEEN INFORMED THAT:

The range of products is injected into the skin to help correct wrinkles, folds and lines of the face and skin, or for lip enhancement. You should be aware that the combination of this particular injectable gel with certain drugs (e.g. beta-blockers) that reduce or inhibit the metabolism of the liver is inadvisable. Ask your medical practitioner for guidance. You should be made aware that this product contains 0.3% of lidocaine (lidocaine is a local anaesthetic, i.e. it alleviates feelings of pain), that may produce a positive results in anti-doping tests. Due to the use of a needle, there is likely to be some bleeding at the injection site. Reactions giving rise to, for example, redness and swelling may occur after the injection, and this may be associated with stinging, itching or discomfort upon pressure at the injection site. This reaction may last for several days. Rarely discolouration of the injection site, necrosis (tissue death), abscess formation, granulomas (small bumps), hypersensitivity and haematomas (excessive bruising) have been reported. Indurations (hardening) or nodules (bumps) may develop at the injection site.

If any of these symptoms persist for more than one week, or if any other side effects develop please report them to your medical doctor as soon as possible so that they can advise you on the best course of treatment. Whilst rare, such side-effects and their treatment may last for several months.

The aesthetic effects of this particular injectable gel range of products can last from 9 to 18 months. Results will vary depending on the condition of the skin, area treated, amount of product injected, injection technique and lifestyle factors such as sun exposure and smoking.

The average life of treatment in the lips is less than in other areas because of the increased activity of the lip area. A touch-up procedure may be required 1-3 weeks after the first injection and helps to optimise the results and maximise the duration of the results.

After treatment, please avoid extreme facial expressions, alcohol consumption and applying make up for 12 hours. Please avoid extreme sun exposure, UV light, freezing temperatures and saunas for 2 weeks after treatment.

Each injectable gel syringe is a single use syringe to be used on one patient only, and should not be stored or re-used after it has been opened as it does not contain a preservative. The syringe and content is sterile when sealed.

MY MEDICAL DOCTOR HAS:

- Explained to me what my health status is, and how the treatment I have chosen may affect my health
- Provided me with sufficient information about the treatment detailed overleaf in order to make an informed decision
- Provided me with treatment options generally available, the benefits, risks and costs associated with each, and I have freely chosen this particular treatment/these treatments
- Provided me with information on the risks associated with the treatment, including the side-effects outlined in this document
- Provided me with instructions as to what my responsibilities are before, and after the treatment, and what I should, or should not do, including the instructions outlined in this document
- Given me the opportunity to ask all remaining questions I may have about the treatment, and has answered them to the best of their ability and I am satisfied with the answers I have received
- Given me the time to consider the treatment detailed overleaf
- Received the relevant medical history information from me and my signature on this form indicates my informed consent to the treatment and my acceptance of the conditions outlined by my doctor and in this document.

I understand that I can withdraw this consent at any stage prior to the commencement of treatment, and that any subsequent decision relating to refusal of continued treatment, including top-ups, will have an effect on the achievement of the treatment. I therefore consent to receiving the described treatment by my medical doctor.

I agree for my doctor to use pictures before and after my treatment for (Please tick the following boxes if you do agree):

◯ **Educational/Training purposes**

◯ **To manage my expectation/outcomes**

Signed: _____ **Date:** _____