Patient Information and Consent Form Platelet Rich Plasma

Description of treatment: *This treatment involves the collection of your blood (approx. 8 to 16mls), then your blood is spun down using a centrifuge to separate out the plasma and platelet portion using the separator gel as a special filter. The PRP portion of your blood is then injected back into your skin to stimulate new collagen production, and to re-energize your cells into rejuvenating themselves. The product injected is 100% your own blood by-product (autologous).*

If you have any questions please do not hesitate to ask Tina Johnson, R.N.

Mr/Mrs/Ms/other: _____

First Name: _____

Surname: _____

Address:

_____

_____

Cell Number: _____

Email:

_____

Date of birth: _____/_____/_____

Occupation:

_____

Emergency Contact
Name:_____

Emergency Contact number:

_____

Relationship to patient:

_____

Pre-testing don't, if any? _____

Blood tests: Full blood count yes/no

Pain Relief option chosen:

_____

Topical applied at: _____

Removed at: _____

Area(s) to be treated today:

_____

Amount of Plasma made:
_____ml(s)

Previous surgical and non-surgical facial Placement notes:

_____

Cosmetic Procedures:

_____

Contradictions: You should not have PRP treatment done if you have any of the following conditions: **Skin conditions and disease including** facial cancer, past and present. This includes SCC, BCC and melanoma, systemic cancer, chemotherapy, steroid therapy, dermatological disease affecting the face (i.e. Porphyria), blood disorders and platelet abnormalities, anticoagulation therapy (i.e. Warfarin).

Tina Johnson, R.N. | (903) 814-7760

Comments:

_____

If you are unsure about any of the above-mentioned conditions, please ask!

Have you ever been told that you suffer from or suspect you suffer from: platelet dysfunction syndrome, critical thrombocytopenia, hypofibrinogenemia, hemodynamic instability, sepsis, chronic liver disease, hepatitis or any acute or chronic infections? **YES / NO** (circle one)

If yes, please state:

_____

Are you currently taking any of the following medications: Aspirin, anti-inflammatory such as Nurofen, Voltaren, Diclofenac, or Naproxen, etc.? St. johns Wort, Garlic, Vitamin E? **YES / NO** (circle one)

If yes, please state which one(s) and last date taken? _____

Are you currently taking, or have you recently taken (within 14 days) Vitamin E, or Fish Oil supplements that could have a thinning effect on your blood? **YES / NO** (circle one)

If yes, please state: _____

SIDE EFFECTS: *you will likely experience mild to moderate swelling of the treated area(s), this will last for about 12 to 24 hours; ice or cold compresses can be applied to reduce swelling if require. You may notice a tingling sensation while the cells are being activated. In rare cases skin infection may occur, which is easily treated with an anti-biotic.*

PATIENT INITIALS:_____

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LASTING Impressions

CLIENT CONSENT

I understand that due to the natural variation in quality of Platelet Rich Plasma, results will vary between individuals. I understand that although I may see a change after my first treatment; I may require a series of up to 6 sessions to obtain my desired outcome.

The procedure and side effects have been explained to me including alternative methods as have the advantages and disadvantages.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment.

I am aware that the PRP treatment is not permanent as natural degradation will occur over time. I authorize **Tina Johnson, R.N** to perform the injection of PRP (Platelet Rich Plasma) for rejuvenation.

This consent form will be valid for up to 6 applications of PRP, after which time I may be asked to complete a new form. I state that I have read (or it has been read to me) and I understand the information contained in it.

I have had to opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled in prior to my signature.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

When completing the medical questionnaire, I have answered the personal medical history questions fully and to the best of my ability.

X_____

Name (printed) **Date**

X_____

Signed Name **Witnessed Signed**

Tina Johnson, R.N. | (903) 814-7760