IADVL- ACADEMY- SPECIAL INTEREST GROUP- LASERS AND AESTHETICS

CONSENT FORM FOR AUTOLOGOUS PLATELET RICH PLASMA (PRP):

Hospital/Clinic: _____

Patient's Name: _____ Age_____

Contact No.: _____

Address: _____

INDICATION FOR PRP----------

I understand that PRP is an injection treatment whereby the patient's own blood is centrifuged to separate out the plateletportion that is then injected back into the skin to stimulate new collagen production and to energize the cells into rejuvenating themselves. The same process is also done for the hair to reduce hair loss and improve the hair growth.

I have been explained about maintenance treatments that may be required after completion of treatment.

The total number of treatment sessions may vary among individuals. Exact number of session cannot be predicted.

No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. On rare occasion there may be a patient who does not respond to treatment.

I was also informed about the other alternative methods as well as their benefits and disadvantages. I understand that for ideal results, this procedure can be combined with microneedling, laser and chemical peels, etc.

I understand the following side effects and complications may be experienced like pain, headache, stinging, mild to moderate swelling which may subside in 3 to 7 days, redness and heat, nausea, vomiting, dizziness and transient increase in sugar levels.

I understand that variable results are seen due to the patients' lifestyle, medical profile, and age, the extent of wrinkling,extent of hair loss, smoking,sun damage, nutritional make-up, and genetic factors.The results depend on the platelet levels and the level of growth factors in these platelets which vary from person to person.I UNDERSTAND that the procedure is not FDA approved for cosmetic indications and approved for wound regeneration

My medical history regarding herpes, allergy, acne, keloids, diabetes, and autoimmune disease, treatment with anticoagulants, NSAIDS, blood thinners or corticosteroids is disclosed correctly. I am not pregnant or breast-feeding.

Topical, local or general anesthesia is required in few patients. I am ready to take the appropriate form of anesthesia.

I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however my name or identity will not be disclosed and complete confidentiality will be maintained.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of Platelet rich plasma treatment.

Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.

I also agree to comply with the recommended aftercare instructions.

I hereby release Dr. and its designated staff from liability associated with the above procedure.

My questions regarding the procedure have been answered satisfactorily.

I authorize Dr. and his/her designated staff to perform Platelet rich plasma treatment on my body.

The payment and fee structure is informed to me. I am ready to pay per sitting or package basis. [Package if opted for includes minimum number of sittings and I have to pay accordingly if more sittings are required]

SIGNATURE OF PATIENT/THUMB IMPRESSION

SIGNATURE OF PARENTS /GUARDIAN (FOR MINORS) DATE:

_____

NAME AND RELATIONSHIP IF SIGNED BY OTHER THAN PARENT

WITNESS: DATE:

NAME_____ SIGNATURE_____

DATE: _____

SIGNATURE OF DOCTOR----------DATE----------

TRANSLATED IN PATIENTS LANGUAGE BY----------