

Patient's Name :-	
Patient ID	
Age:	Gender: male/female
Date:	Location:

INFORMED CONSENT FOR MICRODERMABRASION

MACHINE USED-

TREATMENT AREA

I. _____, (the patient) or representative of patient _____), have (please tick the correct option above and below).

- Read
- Been explained this consent form in _____(name of language) which I fully understand, and understood the information provided about _____ Full name of procedure) given below in this consent form.

Brief description of procedure :

Microdermabrasion is a resurfacing technique consisting of mechanical abrasion of skin with pressurized stream of crystals mostly aluminum oxide or a diamond tipped wand to achieve superficial skin wounding. An attached vacuum simultaneously suctions those exfoliating crystals back into the machine along with dead or loosened skin. Each treatment will last about 15 to 30 minutes patient may feel a mild scratching and a vibrating sensation at the time of the procedure.

Pre treatment and post treatment instructions:

Avoid using glycolic or other alpha hydroxyl acids and retinol products 7 days before and after treatment,

Do not wear contact lenses to treatment session

A strict and religious use of sunscreens

Avoid suntan beds or any strong UV light source for 2 weeks after treatment

Treated area to be kept clean and moisturized

Intended benefits

Microdermabrasion is used to treat light scarring, discoloration, sun damage, eliminating age spots, blackheads, for treating enlarged pores, fine lines and wrinkles and more often for a refreshed appearance.

I understand that all procedures carry certain risks. The potential risks and complications from the procedure are:

There may be mild discomfort, redness or swelling which will subside shortly. Later, the skin may be dry and flaky for several days and more sensitive to sun exposure. Other possible side effects may be bruising, stinging, tenderness and lightening or darkening of skin.

I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like chemical peels, fractional lasers, microneedle RF and dermarollers.

COST AND PAYMENT POLICY:

I have been explained about the cost of each session which is Rs _____

I am going to pay per session / package basis. Package if opted for includes minimum number of sessions and I have to pay accordingly if any additional sessions or treatments are required.

I am now aware of the intended benefits, possible risks & complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful procedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure and understand that it is not possible to list all possible risks and complications of any procedure.

I also understand that sometimes a planned procedure may need to be postponed or cancelled if patients clinical condition demands or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequences, by submitting the withdrawal in writing.

I understand that if medical exigencies demand, further or alternative procedural measures may need to be carried out and in such case there may be difference in the planned and actual procedure.

I am now also aware that during the course of this procedure, the doctor will be assisted by medical and paramedical team, and that the doctor may seek consultation/assistance from relevant specialists if the need arises.

I agree to observing, photography (Still/video/televising) of the procedure (including my diagnosis /reports pathology, radiology, etc)for academic /medical/medico-legal purposes , provided my identity is not revealed by such acts. I also agree to my clinical details being shared for scientific publications if my identity is not disclosed.

I am also aware of the expected course after the procedure and the post procedural care to be taken .

I declare that I have received & fully understood the information provided in this consent form, that I have given an opportunity to ask questions relating to my alignment, the procedure being performed, its risks, consequences, alternatives, potential; complications and intended benefits and recovery and that all my

questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

For the above mentioned operation (s)/procedures(s) that I have been made aware of, I give my consent voluntarily to Dr. (Name of doctor performing the procedure) for carrying out the said procedure on [] myself or [] my above named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

I, above named patient, named patients representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature/thumb impression	Name
Patient		
Surrogate/Guardian (if applicable#)		(Write name relationship with patient
Reason for surrogate Consent	Patient is unable to give consent because	

*Right hand the males & left hand for Female #only if patient is a minor or unable to give consent

Signed by the above on __/__/____ at __:__ AM /PM

I, the undersigned doctor, have explained the nature, potential risks and complications intended benefits, expected post-procedure cause and possible alternatives to the planned procedure, to the patient / patient Representative. I am confident he / she has understood the information fully as described in this document.

Consent obtained by: