**IADVL- Academy**

**SIG (Special Interest Group) Aesthetics 2020-21**

**CONSENT FORM FOR CRYOLIPOLYSIS**

(Please acknowledge the source when using this consent form)

Mr/Mrs./Miss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the PROCEDURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

**Procedure Details:**

 **I HAVE BEEN INFORMED IN THE LANGUAGE I BEST UNDERSTAND THAT**

Cryolipolysis is a non-invasive procedure that is intended to change the appearance of the treatment area by delivering controlled cooling at the surface of the skin to break down fat cells that are just beneath the skin. I understand the general purpose of the treatment is:

1. To improve my physical appearance.
2. To redefine the body contour through the reduction of centimetres.

Results of the treatment will be directly proportional to the ability of my tissues to remove the treated fat and renew the collagen, an effect that may be diminished in very damaged or aged skin, in which case it is possible that the results may not be as expected. This procedure is not a treatment for obesity or a weight-loss solution and does not replace traditional methods such as diet, exercise or liposuction.

I understand that medicine is not an exact science and that absolute and definitive perfection cannot be guaranteed. Patients with small fat deposits will respond better than those who are overweight, and hence, more than one treatment session in the same area is typically required to achieve optimal outcomes. It is recommended to wait a minimum of 6 weeks to repeat the treatment on the same area, although the adipose tissue reduction can last up to three months. Up to 3 areas can be treated on the same day.

**I AM ALSO INFORMED THAT**

While cryolipolysis is a generally safe procedure, one may experience the following during or post the procedure.

* During the session or immediately afterwards – A pulling or pinching sensation, itching, stinging, tingling or mild pain are commonly encountered and are reversible. Paraesthesia and/ or temporary sensitivity, redness or pain maybe encountered. Thermal injuries, nausea, dizziness or vasovagal symptoms are unusual.
* After the session (24 hours onward) – a feeling of stiffness, itching or pinching maybe encountered and mild inflammation in the treated area. Bruising may occur post the procedure and may persist for a week or two. Temporary localised pain and /or redness in the area may occur.
* The rare effects, may include enlargement of the treated area, intensification of pre-existing hernias, and rare nerve disorders (motor derangements due to damage to the marginal mandibular nerve, hypoglossal nerve) and/or dry mouth due to damage to the submaxillary salivary gland. These however are extremely rare.
* Some patients may experience a delayed onset of the aforementioned mentioned symptoms and other unknown adverse events may also occur.
* Medical conditions such as cryoglobulinemia or paroxysmal cold haemoglobinuria ( these are the diseases where you may experience severe joint pains, skin rash etc. after exposure to cold) periodontal disease (local precaution in the double chin area), cold urticaria or raynaud’s disease, Impaired peripheral circulation, neuropathic disorders such as postherpetic neuralgia or diabetic neuropathy and infected wounds and / or fragile skin (dermatitis, psoriasis etc.) in the treatment area are contraindications for treatment and I am not suffering from any of the aforementioned conditions
* Pre and post procedure photographs will be taken which may be used for academic or scientific purposes.

**COST AND PAYMENT**

I have been informed about the fees and the number of sessions / package. I shall abide by the same

**Consent Letter:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her /his designated staff to perform procedure of Cryolipolysis. Further, my signature below indicates my consent for the treatment described and my agreement to comply with the requirements placed on me by this consent form.

I state that I do not have collagen disease; I am not taking, and have not taken during the last 12 months, any medication that may alter my state of immunity; I am not pregnant; I do not take anticoagulants; I do not have any tumours, in remission or otherwise; there are no metal implants or prostheses in the treatment areas; I do not have a pacemaker or any other electronic devices in my body; I do not suffer from epilepsy, heart disease, kidney or liver conditions; and the general state of my health is satisfactory.

I have been 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 other options. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am also aware that follow-up treatments may be necessary for desired results.

My questions regarding the procedure have been answered satisfactorily.

I hereby release Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her/his designated staff from any liability and side effects associated with above procedure. The payment and fee structure have been informed to me and I agree to abide by the same. I also agree to comply with the recommended aftercare instructions.

**SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE (in case of minor)**

**Name:**

**SIGNATURE OF WITNESS SIGNATURE OF OPERATING DOCTOR**

**Name: Name:**

**Date: Time: Place:**

**Was Translation to the Patient’s language required: Yes/ No**

**SIGNATURE OF THE TRANSLATOR (Name and Relationship with the patient, if any)**

**POST PROCEDURE CARE:**

* Avoid scratching the skin as it is very sensitive
* Drink plenty of water
* Avoid hot shower baths, hot tubs and saunas for 48 hrs
* Avoid strenuous exercise for 48 hrs
* Avoid Ice packs so as to ensure very good results
* Use your skin care products and make up as advised by the doctor