**IADVL- Academy**

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

**Consent form for Dermaroller**

(Please acknowledge the source when using this consent form)

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

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

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

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

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

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

Indications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date:

**Procedure Details:**

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

* The purpose of this procedure is to reduce acne scars, improve skin texture and reduce fine lines and wrinkles to some extent which will require multiple sessions.
* The procedure will be performed by my doctor or trained staff.
* The procedure has been explained to me in detail as follows
* To start with, skin will be cleansed with cleansing solutions.
* A numbing cream will then be applied on the area to be treated so as to anaesthetise the skin.
* After 45 minutes to one hour the numbing cream will be cleaned off.
* Skin will be cleaned with sterile/antibacterial solution.
* Then the procedure will be performed with a sterile dermaroller with multiple needles which will be rolled in specific directions for a definite number of times over my skin area to be treated.
* Thereafter a corrective product in the form of serum or gel will be applied over the treated area

**I AM ALSO INFORMED THAT**

* There will be tiny bleeding points at the site of needle pricks
* This procedure may cause redness and swelling of my face which may last for 48 hours.
* There might be crusts which may form after the procedure lasting for 48 to 72 hours.
* There might be pain or burning sensation after the procedure .
* Though this is a safe office procedure, there is a risk of infection and post inflammatory hyperpigmentation if proper care is not taken as per doctor’s advice.
* The results may vary in each individual so no guarantee, warranty or assurance has been made to me regarding the outcome of the procedure.
* There might be activation of herpes or cold sore if I have not revealed previous history to the doctor.
* Pre and post procedure photographs will be taken which may be used for academic or scientific purposes.
* The results may be seen only after 4 to 6 weeks after this session.
* This is not a complete treatment for my ailment and other forms of treatments may be needed for optimum results.

**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 Dermaroller. 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 have informed the doctor about my medical history regarding herpes, allergy, acne, keloids, diabetes and autoimmune disease, treatment with anticoagulants, NSAIDS, blood thinners corcorticosteroids etc. I am not pregnant or breast-feeding. In spite of this, I am aware that I may develop any allergy at any point. I give my consent to the doctor to take the necessary measures to treat my allergic reaction, if any develops. Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.

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.

**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 sun exposure for 72 hours and use a sunscreen prescribed by my doctor while going out thereafter.
* No topical creams, soaps, scrubs or cosmetics are to be applied on the treated area for the period advised by the doctor.
* Excessive sweating should be avoided for the next 48 hrs. Avoid too much of exercise, sudden change in room temperature, hot water bathing can help in this regard.
* Do not opt for any parlour treatments for next 2 weeks or thereafter without consulting the doctor.
* A good diet, adequate water intake and adequate sleep will ensure better healing and good response.
* Attend the next session on the date , as advised by the treating doctor, in order to get the desired result