**IADVL- Academy**

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

**CONSENT FORM FOR HI INTENSITY FOCUSED ULTRASOUND (HIFU)**

(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:

INDICATION FOR PRP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure Details:**

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

High-Intensity Focused Ultrasound (**HIFU**) is a cosmetic treatment for skin tightening. It is a noninvasive and painless replacement for face lifts.

It uses ultrasound energy to encourage the production of collagen, which results in firmer skin.

The purpose of this procedure is to tighten sagging skin in the area.

The procedure requires more than one treatment and may produce some reduction in the appearance of sagging skin and/or wrinkles.

The total number of treatments and clinical results may vary between individuals.

Most patients require a number of treatments over several months with gradual results occurring over this time.

**I AM ALSO INFORMED THAT**

* Short-term effects may include reddening, mild swelling, mild burning and temporary bruising. These conditions usually resolve within 1-3 months.
* Rarely temporary numbness of the treated skin may be seen after treatment and will resolve with time (generally days to weeks).
* Infection: Although infection following treatment is unusual; bacterial, fungal and viral infections can occur. Should any type of skin infection occur, additional treatments might be necessary
* Variable results are seen due to the patients’ lifestyle, medical profile, age and the extent of severity of sagging which varies from person to person.
* The procedure is not FDA approved for cosmetic indications.
* Topical, local or general anesthesia is required in few patients. I am ready to take the appropriate form of anesthesia.
* Pre and post procedure photographs will be taken which may be used for academic or scientific purposes.
* This is not a complete treatment for my ailment and other forms of treatments may be needed for optimum results.
* There are some other treatments which may help my concerns and those options were adequately discussed with me.

**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 Hi Intensity Focused Ultrasound (HIFU). 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 or corticosteroids 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 radiofrequency, surgical options, etc. 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 the Sun for one week and use sunscreen regularly
* 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
* Waxing , tweezing and depilation can be done after 72 hrs