**IADVL- Academy**

**SIG (Special Interest Group) Aesthetics 2020-2021**

**CONSENT FORM FOR AUTOLOGUS MICROGRAFTING**

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

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

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

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

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

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

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

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

Date:

**Procedure Details:**

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

Autologus Micrografting is an injection treatment whereby the patient’s own micrografts are processed to separate out the cellular suspension 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. This treatment is usually used for hair fall treatments, skin rejuvenation and also to stimulate ulcer healing and treat leukoderma. Usually one session is performed in a year however sometimes more treatment sessions may be required. I have been explained about maintenance treatments that may be required after completion of treatment.

## Contraindications to treatment:

* Allergies to any of the used materials/products
* General surgical contraindications.

**I AM ALSO INFORMED THAT**

* Complications and risks of this intervention are rare, but they do exist and include: Numbness, tingling, abnormal scars, insufficient result, etc
* There may be some degree of discomfort, stinging, pin prick sensation, at the time or after the procedure and usually subsides in 3-7 days.
* 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.
* All autologous micrograft treatments are not FDA approved.
* 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.

**COST AND PAYMENT**

* I have been informed about the cost of each session.
* I am going to pay per session / for the package which includes\_\_\_ number of sessions.
* In case additional sessions are needed I will have to pay separately.
* I know that in spite of paying, there could be a situation where session would be postponed depending on the condition of the skin and doctor’s decision will be final in that regard.

**Consent Letter:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her /his designated staff to perform procedure of Autologus micrografting. 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 other treatments. 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. I understand the procedure, the risks, complications and after care.

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:**

* Take medical treatment for your aliment as advised by your dermatologist
* Avoid applying any cosmetics, hair oils etc. on the treatment area for next 72 hrs.
* Follow up regular wound care for the graft donor area as advised by your dermatologist.
* Inform immediately if any delay or difficulty in wound healing.
* The results shall be seen over the period of next 8-16 weeks.