**IADVL- Academy**

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

**CONSENT FORM FOR MICRONEEDLE RF**

(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:

Name of Machine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure Details:**

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

* Microneedle radiofrequency involves insertion of fine electrodes mechanically into the skin followed by the discharge of small amount of radio frequency energy at the desired depth. This leads to stimulation of new collagen production and restructuring of old collagen bundles in the skin.
* The area of treatment is cleansed with cleansing soltutions.
* A numbing cream is applied for 45min to one hour to anaesthetise the skin.
* The anaesthetic cream is then removed from the skin and is cleaned with an antibacterial /sterile solution.
* In case the treatment area is face, eyes are covered with gauze.
* Parameters are set on the machine depending on the indication and area to be treated.
* Handpiece is then held in contact with the skin and single or multiple passes are done on the treatment area.
* Any minor bleeding or oozing is wiped off once done.
* A serum /gel containing required ingredients or antibiotic cream is applied to the area.

**I AM ALSO INFORMED THAT**

* There may be some degree of discomfort, stinging, pin prick sensation, warmth, burning or itching at the time or after the procedure. It may cause my skin to appear pink and flaky and it may take a few days to weeks before the skin returns to its normal appearance. However, some patients react differently.
* Short-term effects may include mild to moderate discomfort or pain, slight redness or swelling, sun sensitivity, skin sensitivity. These conditions usually self-resolve
* Rarely acneiform eruptions, pigment changes, blistering, scarring, allergic reaction and secondary infection may happen.
* 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.
* 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. I understand that for ideal results, this procedure can be combined with PRP, Laser, Botox etc.

**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 Microneedle RF. 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 Botox, PRP, laser 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. 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:**

* 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