Dermapen™ CLINICAL TREATMENT CONSULTATION & CONSENT FORM

DATE

DERMAPEN™ CLINIC

DERMAPEN™ PRACTITIONER

PATIENT DETAILS

FULL NAME | DATE OF BIRTH

ADDRESS

TELEPHONE (M) | (H) | (W)

EMAIL ADDRESS

EMERGENCY CONTACT DETAILS

FULL NAME

RELATIONSHIP

TELEPHONE (M) | (H) | (W)

EMAIL ADDRESS

WHAT ARE YOUR PRIMARY SKIN CONCERNS THAT YOU WISH TO BE TREATED WITH DERMAPEN™?

DO YOU HAVE ANY IMPORTANT PERSONAL ENGAGEMENTS IN THE NEXT WEEK? Y ○ N ○

DO YOU HAVE ANY KNOWN ALLERGIES? (E.G. LATEX, METALS, SHELLFISH, NUTS, PENICILLIN, ANAESTHETIC AGENTS, P-AMINOBENZOIC ACID (PABA), SULPHONAMIDE ALLERGIES)

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING ACTIVE SKIN CONDITIONS?

- ○ Papulopustular rosacea
- ○ Acne vulgaris stage III-IV
- ○ Herpes simplex
- ○ Dermatomyositis
- ○ Warts
- ○ Scleroderma
- ○ Pemphigus/pemphigoid
- ○ Bacterial/fungal Infections
- ○ Open lesions
- ○ Solar keratosis
- ○ Skin cancer

HAVE YOU EVER EXPERIENCED ANY ADVERSE REACTION TO ANY FORM OF ANAESTHETIC?

ARE YOU CURRENTLY UNDER MEDICAL SUPERVISION FOR ANY OF THE FOLLOWING? Y O N O

O Cardiac conditions/ arrhythmia
O Auto-immune disorder
O Haemophilia
O Hepatic disease
O Diabetes (type I or II)
O Cancer
O Human Immunodeficiency Virus (HIV)
O Pseudo cholinesterase deficiency
O Congenial or idiopathic methemoglobinemia

ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? Y O N O

ARE YOU CURRENTLY TAKING (OR HAVE TAKEN IN THE LAST 3 MONTHS) ANY OF THE FOLLOWING MEDICATIONS OR SUPPLEMENTS? (PLEASE TICK)

O Isotretinoin (including but not limited to Roaccutane®/ Accutane®/Isotane®)
O Anti-coagulants/blood thinners (including but not limited to Warfarin or aspirin)
O Photo-sensitisers (including but not limited to anti-depressants/anti-anxieties/antibiotics)
O Contraceptive pill
O Fish oils/plant oils/omega 3s
O ginseng/gingko biloba/St John's wort

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES IN THE LAST 2 WEEKS ON THE AREA TO BE TREATED WITH DERMAPEN? (PLEASE TICK)

O Plastic/Cosmetic surgery
O Muscle relaxant/wrinkle reduction injections (including but not limited to Botox®or Dysport™ or Xeomin®)
O Dermal Fillers (including but not limited toJuve derm®, Restylane®, Belotero®, Captique® Esthelis®, Radiesse®, Aquamid®,Sculptra® or Artefill®)
O Microdermabrasion
O Chemical peel (including but not limited to glycolic acid, lactic acid, mandelic acid or salicylic acid)
O Derma blading/derma planing
O Laser/IPL rejuvenation/hair removal
O Radio Frequency (RF) skin tightening
O Photo dynamic therapy (PDT)
O Dermabrasion
O Deep chemical peel
O Tattooing/cosmetic tattooing
O Electrolysis/diathermy
O Hair removal (including but not limited to waxing, sugaring, plucking, threading or depilatory cream)
O Spray/self-tanning

HAVE YOU USED ANY PRODUCTS CONTAINING ANY OF THE FOLLOWING INGREDIENTS ON THE AREA TO BE TREATED WITH DERMAPEN™ IN THE LAST WEEK? (PLEASE TICK)

O Alpha/beta hydroxy acids (including but not limited to glycolic acid, lactic acid or salicylic acid).
O Retinoids (Vitamin A) (including but not limited to tretinoin, retinol or retinaldehyde)
O Benzoyl peroxide/adapelene (Differin®)
O Hydroquinone/kojic acid/azelaic acid

I, ... have completed the Dermapen™ Clinical Treatment Consultation & Consent Form honestly and to the best of my knowledge. My Dermapen™ practitioner has provided me with a Dermapen™ Pre-Treatment Form and a Dermapen™ Post-Treatment Form and has thoroughly explained to me:

- What a Dermapen™ clinical treatment is
- How a Dermapen™ clinical treatment works
- Expected outcomes of my Dermapen™ clinical treatment
- Dermapen™ clinical treatment contraindications and considerations
- Anaesthesia protocols
- Post-op care

I understand that a course of Dermapen™ clinical treatments will be required for optimum results.

Patient signature ....

Patient name (Printed) ....

Date ....

Dermapen™ practitioner signature ....

Dermapen™ practitioner name (Printed) ....

Date ....