

## YOUR DECISION:

## MICRONEEDLING

Microneedling is a cosmetic procedure that involves repeatedly puncturing the skin with tiny, sterile needles. The technique may help with skin problems such as scarring, acne, wrinkles and lines.

While our Microneedling system is a safe procedure that is suitable for most people, it is not suitable for everybody. It must be advised that you should not proceed with this treatment, if you currently suffer from the following conditions:

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| Have you had Botulinum Toxin Type A or fillers within the last 6 months?                   | YES / NO |
| Is the scar in questions to be treated less than 6 months old?                             | YES / NO |
| Do you suffer from any collagen vascular disease?  | YES / NO |
| Do you have any bacterial or fungal infections?  | YES / NO |
| Do you have Scleroderma?   | YES / NO |
| Do you suffer from an Autoimmune Condition and/or presently taking any immune suppressors? | YES / NO |
| Do you suffer from Rosacea?  | YES / NO |
| Do you suffer from acute/chronic skin conditions or benign/malignant lesions?              | YES / NO |
| Do you suffer from seizures, black outs or epilepsy?                                       | YES / NO |
| Do you suffer or have you suffered from any heart conditions or complaints?                | YES / NO |
| Are you pregnant, or trying to become pregnant?  | YES / NO |
| Are you breastfeeding?   | YES / NO |
| Have you ever had an allergic reaction Latex or non-surgical products?                     | YES / NO |
| Have you ever had a reaction to topical anaesthetic?                                       | YES / NO |

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The following conditions may not inhibit you from having the treatment performed, but the practitioner does need to be aware of them:

History of Eczema or Dermatitis?	YES / NO
Pigmentation problems including a history or of susceptibility to Keloid, raised/hypertrophic scarring?	YES / NO
History of Diabetes?	YES / NO
Psoriasis and any other chronic conditions?	YES / NO
Presence of raised moles?	YES / NO
Herpes simplex infection/cold sores?	YES / NO
Warts or raised lesions in area to be treated?	YES / NO
Any known allergies?	YES / NO
Have you recently used a sunbed, tanning products or had sun/UV exposure or sunburn?	YES / NO
History of actinic keratosis?	YES / NO
Thrombosis or any blood clotting problems?	YES / NO
Do you bruise easily?	YES / NO
Bleeding disorder or blood related illness, anaemia, sickle cell, thalassemia, hepatitis A/B/C or HIV?	YES / NO
Have you ever had an allergic reaction to Lidocaine or Propylene Glycol?	YES / NO
Are you currently taking any medications or using any topically prescribed creams?	YES / NO
Have you undergone any other form of cosmetic treatment or surgical procedure in the last 12 months?	YES / NO

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I have read the above information and consent to have Microneedling treatment.

I understand that whilst steps have been taken to minimise potential risks associated with this procedure there is a chance that I may experience side effects during and immediately after treatment including tightness, stinging, itching, Erythema and swelling. These have been explained to me and I accept responsibility for them.

If I have any questions about the treatment I will ask the practitioner before treatment begins.

I understand that photographs may be taken before, during and after the treatment. The purpose is to demonstrate and compare the differences prior to and after treatment. These will be retained for our records. If we were to use them for education or marketing purposes all identifying marks would be cropped or removed.

I accept that no guarantees can be made about the outcomes of the procedure as these vary for each individual.

I have been advised to seek medical advice prior to agreeing to any treatment being performed.

I understand more than one treatment is usually required to achieve optimal results.

I agree not to bring any claim in connection with services provided by this clinic against any employees or subcontractors on a personal basis.

**CLIENT:** Name:..... Signature:..... Date:.....

**Clinician:**  
I confirm I have summarised the relevant consent information verbally & checked understanding.  
**Clinician Signature:**  
.....  
**Date:** .....

**Additional Notes/Lot Numbers of Products**  
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