Dr. Manal Younis

CONSULTANT GYNAECOLOGIST & MEDICAL AESTHETICS

YOUR DECISION:

PN & PDRN INJECTIONS)

First Name:_______________________________

Last Name:_______________________________

Date of Birth:____/____/____

Contact Number:_______________________________

Email Address:_________________________________

Emergency Contact:____________________________

Full Address: _______________________________
____
____
____

Medical Conditions OR MEDICATION
Please list any medical conditions or medication you have or had in the last 6 months.
____
PREGNANT OR NURSING YES OR NO
ALLERGIES: Please tick any of the allergies you have or list any which are not down.
LANOLIN | RUBBER | VASELINE | MEDICATION METALS | HAIR DYES |
FOODS | LIDOCAINE PAINTS | LATEX | GLYCERINE | OTHER ________________________
If yes please write down what type of reaction happens?
____
CHOSEN TREATMENT
Please circle treatments you have chosen
____
SKIN PATCH TEST
DATE AND TIME OF PATCH TEST______________________________
CHOSEN TREATMENT AND PRODUCT:_______________________________
ALTERNATIVE PROCEDURES
Alternatives to the procedures and options that I have volunteered for have been fully explained to me.
PLEASE INITIAL:
RIGHT TO DISCONTINUE TREATMENT
I understand that I have the right to discontinue treatment at any time.
PLEASE INITIAL:

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RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that may not be discussed. Some of these risks, if they occur, may necessitate hospital treatment, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure.

I hereby give verbal and written consent for the cosmetic practitioner at ……………………to carry out the chosen treatment and release the practitioner and the facility from liability associated with any procedure.

Consent must be given voluntarily and not under any form of duress or undue influence from health professionals, family or friends.

Client Name………………………………… Date…………………………..

Clients Signature……………………………

I am the treating practitioner. I discussed the above risks, benefits, and alternatives with the patient on their chosen treatment/s. The patient had an opportunity to have all questions answered. The patient has been told to contact my office or myself should they have any questions or concerns after this treatment procedure.

Practitioners Signature……………………………………

YOUR DECISION:

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TREATMENTCONSENTFORM

REJURAN (PN AND PDRN INJECTIONS)

PLEASE BE ADVISED YOU MUST READ THIS AGREEMENT AND SIGN BEFORE ENTERING THE TREATMENT ROOM.

The Client I have consulted my doctor within the last 3 months in regards to any medical concerns. This disclaimer is acknowledgement that I have not been miss sold upon today and have been given enough time to contemplate and agree to today's service with a full understanding of how the treatment works. I am aware that the treatment I am consenting to may be a process and that Benefits can vary on different individuals. I have been informed of the correct and informative knowledge by my therapist and I am happy to go ahead with today's service. I give full permission in the event of an emergency for a trained and qualified therapist to perform first aid if required. I have given a full and accurate medical history. Any medical concerns have been questioned and dealt with by my doctor.

I understand that I am not being treated medically for medical issues, I authorise the practitioner to carry out the treatment which uses the product "Rejuran Healer" to help improve skin quality. This treatment is not immediate and takes weeks to start seeing results and will require numerous sessions to receive the best results. No results can be guaranteed with treatment, however there is significant evidence that shows the product improves skin quality.

There is any reactions known other than the treatment being carried out at the same time of Dermal fillers as if done at the same time it can stimulate granuloma formation. So on signing this form I agree I will not have this treatment at the same time as hyaluronic acid fillers or have hyaluronic fillers after. The main after effect are small lumps where the injection has been, this is not a lunch time treatment (meaning you will have down time) around 2-3 days for swelling to go down. I am also consenting to knowing the fact that injecting any substance into my body there will always be a small risk of any type of reaction.

Reason for treatment:____

____

ARE YOU VEGAN OR VEGETARIAN? (This treatment derives from Salmon) YES/NO

Area treated:________________________________

Name"________________________________

Date:________________________________

Practitioners Signature:________________________________