Dermapen 4™ INFORMED CONSENT FORM DERMAPEN TREATMENT

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 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
- ◯ Other _____

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

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

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

ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING?

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

- ◯ Isotretinoin (including but not limited to Roaccutane®/ Accutane®/Isotane®)
- ◯ Anti-coagulants/blood thinners (including but not limited to Warfarin or aspirin)
- ◯ Photo-sensitisers (including but not limited to anti-depressants/anti-anxieties/antibiotics)
- ◯ Contraceptive pill
- ◯ Fish oils/plant oils/omega 3s
- ◯ 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)

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

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

Brand/Product details:

CONSENT

I, ... have completed the Dermapen™ Clinical Treatment Consultation & Consent Form honestly and to the best of my knowledge. My Dermapen™ Treatment Provider 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 - Pros & Cons
- 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