PATIENT INFORMATION & CONSENT

Patient Name: _____ **Date of Birth:** _____

OCCUPATION: _____ EMAIL: _____

CELL:_____ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ TEL #:_____

PLEASE READ EACH SECTION CAREFULLY. YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR OWN RECORDS.

This treatment involves the collection of your blood (approximately 8-16ml), then your blood is spun down using a centrifuge that separate out the plasma and platelet portion using the separator gel a special filter. The PRP portion of your blood is there at the point of care to re-energize your cells into rejuvenating themselves. The product is 100% your own blood by-product (autologous).

If you have any questions please to not hesitate to ask your nurse practitioner.

PRE-TREATMENT DETAILS:

Pain relief option chosen: _____

Topical applied at: _____ Removed at: _____ Amount of plasma made: _____

Previous surgical and non-surgical facial placements notes: _____

Cosmetic Procedures: _____

CONTRAINDICATIONS:

YOU SHOULD NOT HAVE PRP TREATMENT DONE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:
Skin conditions and diseases including: Facial cancer, existing or uncured. This includes SCC, BCC and melanoma, systemic cancer, chemotherapy, steroid therapy, dermatological diseases affecting the face (i.e. Porphyria), Blood disorders and platelet abnormalities, Anticoagulation therapy (i.e. Warfarin)
COMMENTS: _____

HAVE YOU EVER BEEN TOLD THAT YOU SUFFER FROM OR SUSPECT YOU SUFFER FROM:
Platelet dysfunction syndrome, critical thrombocytopenia, hypofibrinogenaemia, hemodynamic instability sepsis, chronic liver disease, Hepatitis or any acute chronic infections?
YES / NO *(circle one)*
If yes, please state: _____

_____ _____

Printed Patient Name **Date** **Signature of Patient**