THE HAYNES ST ESTHETIC CLINIC

Consent to Medical Skin Needing Treatment

The Clinic is required to collect from clients the information in this form.
Thank you for your understanding. Contents are kept confidentially.
PLEASE USE BLOCK LETTERS IN ALL FORM FIELDS

Are you currently taking any medication - YES or NO?

IF YES, PLEASE LIST HERE

Do you suffer from any medical conditions - YES or NO?

IF YES, PLEASE LIST HERE

Please tick:

- I understand that there may be some degree of discomfort including inflammation, bruising and redness with having this treatment.
- I understand that a topical anaesthetic will be applied to numb my skin prior to the treatment
- I understand that my skin will be pricked repeatedly so it will lose some blood (this stops within minutes and then a straw coloured fluid may ooze from the tiny holes. This also stops within a few minutes)
- I understand that there are no guarantees to the results of this treatment due to variables such as age and condition of the skin.
- I understand that for the first 24 hours after the treatment I only apply the products recommended and not apply any makeup or sunscreen (this is due to the micro channels remaining open for 24 hours after)
- I understand that this is a cosmetic treatment and no medical claims have been implied.
- I understand to achieve maximum results, I may need several treatments.
- I understand that although complications are very rare, sometimes an unexpected outcome may occur and that prompt treatment would then be necessary. If anything occurs, I will immediately contact the therapist that performed the treatment in order to be referred on to a medical doctor.

I, (insert your name) …… …… …… …… …… …… …… hereby

authorise (insert name) …… …… …… …… …… …… …… to perform the procedure of Medical 1mm Skin Needling. I understand the nature of the treatment and the risks involved have been explained to me in full. I also agree to follow post-care treatment advice and to use only the skin care products as recommended by the qualified person that conducted the procedure. I acknowledge that whilst certain benefits are likely to result from this treatment as discussed with me, I acknowledge that individual results will vary and that no guarantee of a likely outcome can or has been given.

PRINT NAME: …… …… …… …… …… …… ……
(Patient or guardian)

SIGNATURE: …… …… …… **DATE:** …… …… ……