dM cosmetic & wellness centre

eDermastamp MICRO-NEEDLING CONSENT

This consent form is designed to give you the information you need to make an informed decision about whether or not to undergo eDermastamp Micro-needling for the purpose of skin surface improvement. If you have any questions, please ask our staff. Please initial all paragraphs, sign and date document.

Micro-needling is an effective non-ablative procedure using a medical needling technique to help improve skin texture, elasticity, wrinkles and fine lines, skin crepiness, scars and stretch marks.

Microscopic punctures in the skin stimulate a release of platelets which in turn generates a release of growth hormones and new skin cells. During the treatment period and for about 5 months following the treatments, treated skin experiences renewed growth, by a proliferation of fibroblast cells, responsible for collagen and elastin.

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_____ My skin may be prepared with a topical anaesthetic cream. The risks, side effects, complications of these topical anaesthetics may include skin irritation (itching or redness), and much more rarely, light headedness, rapid heart rate, visual disturbances and tongue numbness.

_____ Like any cosmetic treatment, there are no guarantees because results vary based on a number of factors such as skin deterioration, smoking, sun exposure, overall health, skin health, number of treatments, responsiveness to treatments, etc. I understand that best results are achieved when combined with skin care treatment.

_____ During treatment, I will experience some minor bleeding. Inflammation and redness can be expected for about 2 to 48 hours. To minimize risks, I have stopped taking ASA products or anticoagulants for 5 days before my first treatment.

_____ I have disclosed my medical history, allergies and medications. The spread of an infection can occur as well as exacerbating an existing medical condition.

_____ I agree to advise Dr. Matta and the staff of DM Cosmetic and Wellness Centre of any changes to any medical conditions or health throughout the treatment period.

_____ I understand that if I have active herpes, acne or skin infection, treatment may be delayed until the condition has resolved.

_____ I understand treatment can trigger a herpes flareup.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta

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_____ I have disclosed my health history and do not have: skin cancer, impetigo lesions anywhere on the body, allergy to local anaesthetic agents, uncontrolled diabetes any blood OR bleeding disorders, haemophilia, HIV/AIDS; hepatitis or keloid scarring.

_____ I am not immune compromised and/or being treated with chemotherapy, high doses of corticosteroids, or radiotherapy.

_____ I agree to allow Dr. Matta to photograph the treatment area before treatment, at the end of the treatment and 5 months after the treatment and authorize their anonymous use for the purposes of medical audit, education and promotion.

_____ Micro-needling is cosmetic and not medically necessary. It is not covered by my insurance plan.

_____ I agree to allow the staff of DM Cosmetic and Wellness Centre to treat me and to follow-up or contact with the office if I have any issues of concern.

_____ I agree to follow the post instructions sheet.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta