SELPHYL PATIENT CONSENT FORM

Selphyl is a system designed for the preparation of a Platelet Rich Fibrin Matrix from your own blood, which can then be injected into the treatment area to assist in tissue regeneration.

The use, benefits, and side effects of receiving PRFM have been explained to me, and I understand all the information provided.

PRFM can be used in any age group. Although a 25-30% correction is anticipated it cannot be guaranteed and will be affected by intrinsic aging and lifestyle considerations such as diet, drugs, tobacco and alcohol. It is recommended to do 2-3 sessions 4-8 weeks apart. Maintenance may be done every 1-2 years.

Initial HERE

_____ I understand that studies using the Selphyl system in children, pregnant and breast-feeding women have not been conducted or reported.

I understand that the potential adverse effects of receiving PRFM may include:

- Inflammatory reactions such as redness, edema and pain in the injected area
- Swelling, puffiness or itchiness at the injection site
- Rarely, granulomas may develop, requiring medical intervention including steroids and antibiotics
- Bruising which is related to the needle not the Selphyl. I understand that ASA, Motrin, Aleve, any NSAIDs, Ginko Biloba, Omega 3, EFA's, flax or cod liver oil, Green tea, Vit.

_____ A or E, Garlic may increase the risk of bruising.

Contraindications associated with PRFM include:

- Areas of infectious skin problems or systemic infections
- Persons susceptible to hypertrophic scarring or autoimmune diseases such as Scleroderma
- Persons with critical anemic, or severe platelet dysfunction conditions
- Persons on medication that can affect platelet function like cortisone, chemotherapy or anti-coagulants

_____ • Cancer, chronic liver disease or severe metabolic conditions

_____ I consent to the injection of a PRFM derived from my own blood.

_____ I understand that any treatment provided may or may not meet my expectations. I understand and agree that there is no compensation or refund of monies paid in any event.

_____ I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

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