Consent for HIFU

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WHAT TO EXPECT DURING AND AFTER YOUR HIFU TREATMENT?

- You can expect to experience some discomfort as the ultrasound energy is delivered. Your Aesthetic Practitioner will agree on a plan to optimise your comfort during the procedure.
- HIFU treatment is efficient. For example, a treatment for the full face and neck will last pproximately 90 minutes.

POSSIBLE SIDE EFFECTS OF HIFU TREATMENT

- Your skin may appear red for a few hours after HIFU treatment.
- You may experience slight swelling, tingling or tenderness for a few days after treatment. Rarely, some people may experience temporary bruising welts or numbness.
- There is a slight risk of a burn to the skin, which may or may not lead to scarring. Both a burn and any scarring will respond to medical treatment.
- Temporary nerve inflammation will resolve in a few days or weeks.
- If a motor nerve has become inflamed, you might experience some temporary local muscle weakness. There could be some temporary numbness if a sensory nerve has become inflamed.

DECLARATION

- I have read and understood all the information provided and I have had the opportunity to ask any questions concerning the nature of the treatment, its expected results, and its possible risks and complications.
- It has been explained to me that the results of HIFU treatment can vary from person to person. I am aware that occasionally the collagen that builds in the deep layers of the skin, providing support for the skin structure and helping to counter the effects of gravity, might not have a visible effect on the surface of the skin.
- I also understand that the results will be seen gradually over a period of 3 months and that some people will benefit from more than one treatment.
- I understand that HIFU treatment is a non-invasive treatment. It is not designed to produce thesame results as an invasive surgical procedure.

☐ I have read the above and consent to receiving the treatment at my own discretion.

PHOTOGRAPHS

☐ I authorise the taking of photographs and video footage which will be retained as a private record for the clinic and practitioner.
☐ I ALSO CONSENT THE USE OF MY PHOTOGRAPHS AND VIDEO FOOTAGE FREE OF CHARGE FOR MARKETING PURPOSES.

Patient Name:	
Email:	Date:
Medical and Surgical History	
Age:	Gender: ○ Male ○ Female
Weight:	Height:

Active wounds
○ Yes ○ No

Active severe or cystic facial acne
○ Yes ○ No

Metal stents in the treatment area
○ Yes ○ No

Implanted electrical devices
○ Yes ○ No

Pregnant or lactating
○ Yes ○ No

Migraines
○ Yes ○ No

Bell's palsy
○ Yes ○ No

Mechanical or other implants in the treatment area
○ Yes ○ No

Active or local skin disease that may alter wound healing*
○ Yes ○ No

Autoimmune disease
○ Yes ○ No

Epilepsy
○ Yes ○ No

Herpes or cold sores
○ Yes ○ No

Diabetes
○ Yes ○ No

Haemorrhagic or bleeding disorders
○ Yes ○ No

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Undergone the following cosmetic procedure in the brow or lower face and neck area: Facial skin tightening procedure treatment within the last 1 year
◯ Yes ◯ No

Filler (i.e. juvederm® or Sculptra®) within the last 3-6months
◯ Yes ◯ No

Neurotoxin (i.e. Botox® or Dysport®) within the last 3-6months
◯ Yes ◯ No

Ablative resurfacing laser treatment
◯ Yes ◯ No

Non-ablative resurfacing laser treatment
◯ Yes ◯ No

Dermabrasion or deep facial peels
◯ Yes ◯ No

Lipo-plasty in the face or neck regions
◯ Yes ◯ No

Facelift or blepharoplasty or brow lift
◯ Yes ◯ No

Are you currently taking the following prescription medications?
☐ Accutane within the last 12 months
☐ Anticoagulants or antiplatelet drugs
☐ Immunosuppressant drugs

List all medications or supplements below. Be sure to include all prescription or non-prescription medications.
If you are not taking any medications or supplements, please leave them blank:

Medication			
Medication:	Condition:	Dose/ Frequency:	Date started:
Medication:	Condition:	Dose/ Frequency:	Date started:
Medication:	Condition:	Dose/ Frequency:	Date started:
Medication:	Condition:	Dose/ Frequency:	Date started:
Medication:	Condition:	Dose/ Frequency:	Date started:

HIFU Consult Record

Everyone is different, the clinical factors listed below are intended to assist your clinician in forecasting your clinical response to HIFU treatment. Please score each clinical factor listed below. Upon examination of your responses, I will discuss your options for achieving optimum results with HIFU treatment.

Please select your age group: ◯ 35 ◯ 36-49 ◯ 50-64 ◯ 65+

Smoking History please select: ◯ Never smoked ◯ Ex-smoker ◯ Light smoker ◯ Heavy smoker

Health: ◯ No health issues ◯ Minor health issues ◯ Chronic health issues

Sun exposure: ◯ Never use sunscreen ◯ Occasionally use sunscreen ◯ Always use sunscreen

Clinical response Factors: *(Upper face and neck: Check the appropriate tick)* ◯ None ◯ Mild ◯ Moderate ◯ Severe

Skin Laxity: *(Excess skin or hooding on the eyelid; eye droopiness)* ◯ None ◯ Mild ◯ Moderate ◯ Severe

Volume: *(Presence of fat deposits under eyes; infra-orbital puffiness Clinical response Factors- Lower face and neck: Check the appropriate None Mild Moderate Severe)* ◯ None ◯ Mild ◯ Moderate ◯ Severe

Skin Quality *(Fine lines, creepiness/wrinkling, and/or poor elasticity)* ◯ None ◯ Mild ◯ Moderate ◯ Severe

What are your treatment Goals?

Additional findings:

Signature:

These records are private and confidential, this document is the property of Dermaesthetique clinic.