Simply Fox

PLASMA PEN CONSULTATION AND CONSENT FORM

YOUR PLASMA PEN CONSULTATION RECORD

Plasma Pen is a procedure that can only be performed by a specifically trained and qualified specialist therapist using approved equipment to shrink the skin using a sterile disposable probe. Your specialist technician is trained, qualified by Plasma Pen, has certification and is fully insured.

Before carrying out the treatment then you are, as a patient, required to complete and sign all relevant areas of this consultation record thus giving your absolute consent to treatment. Additionally, you will need to disclose your full medical history as that will determine whether you are a suitable candidate for the proposed treatment. If the specialist does not think you are suitable for the treatment, then your treatment cannot and will not be carried out.

Your specialist will discuss your procedure with you, in full, including what it will involve and the likely benefits. Realistic expectations will be agreed, and they will explain any risks, the healing process and will then advise you upon any further treatment you may require if/where necessary. You will then be provided with written aftercare information for you to keep and refer to during the subsequent healing process and it is essential you follow these instructions. Any contra-indications will be recorded on this consultation form and will be used as a reference for any future visits.

It is important that you clearly mark any areas of this form that you wish to have clarified or discussed further. It is ultimately YOUR responsibility to ensure that you understand, in full, the Plasma Pen procedure and the expected outcomes BEFORE your treatment commences.

PLEASE READ ALL OF THE FOLLOWING CAREFULLY AND SIGN, WHERE INDICATED, when you are happy to proceed. You must ensure that all the points below have been discussed with your specialist technician. You are signing to state you understand and accept the terms of your treatment.

TERMS OF YOUR TREATMENT:

- You have chosen an elective cosmetic procedure that is not medically necessary
- “Fibroblasting” with Plasma Pen is an artistic process - not an exact science - and it cannot guarantee an exact shrinkage result due to individual skin elasticity, the individual healing process and a range of other factors
- Some results can be cumulative for optimal effects to be achieved and you may thus be required to return for additional treatments before your overall procedure is deemed complete. The payment for any additional work, if applicable, will be agreed with you prior to your treatment commencing
- Depending upon the area of your treatment, additional treatments cannot usually be preformed until 12 weeks after the date of your initial treatment. This is in order to allow the area treated initially to fully heal and for the full benefit of Plasma Pen to be apparent
- Your specialist will use a treatment plan to record the areas that you have chosen, the anaesthetic used, the probe used as well as pre and post treatment photographs. This information will be held securely in your consultation record. Without these photographs and these signed documents/forms then your technician will not be insured
- The skin type of every client is different and the healing process may in rare cases lead to some discolouration of the skin. Microdermabrasion, skin rejuvenation or other relevant treatment may thus be advised after the healing process is complete should this be the case
- After each treatment some mild swelling or redness may occur which is completely normal. In some rare cases there may be extreme swelling. Your specialist will give you appropriate advice and aftercare technique to help reduce this eventuality
- During your treatment you may experience some minor discomfort depending on the area being treated. Your specialist will reassure you throughout and endeavour to make you feel comfortable

- Since the treatment includes small burns to the skin, you may experience the smell of charring during your treatment. This is perfectly normal
- You must adhere to the specialist's aftercare advice given to you following your treatment. This is very important as it will reduce the risk of post-procedural infection upon leaving the clinic. You must let the treated area heal properly. Avoid picking, plucking or knocking as this will hinder the healing process and could make the treatment appear uneven thus requiring further work. Your aftercare regime can make a huge difference to your ultimate results
- Please be aware that any subsequent skin altering procedures such as plastic surgery, implants, injectables and weight gain may alter the Plasma Pen look.

TO BE COMPLETED BY THE CLIENT

YOUR FULL NAME: DATE OF BIRTH (DD/MM/YY):

ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

PHOTOGRAPHIC CONSENT (To be signed by the client):

I hereby grant consent to photographs being taken BEFORE, DURING and AFTER my Plasma Pen procedure. I agree to these being stored with my case file and that they will only be used with my written consent for any additional promotional purposes.

Client Signature:

MEDICAL FORM: (To be completed by the client)

Have you received any skin tightening treatment before? YES / NO

If YES please answer the following questions:

1. How long ago was your treatment?
2. What procedure(s) did you receive?
3. At what clinic did you receive the treatment?
4. Where you happy with the result? YES / NO
5. If NO, please explain the reasons why:
6. Are you over the age of 18?
7. Are you pregnant or breastfeeding?
8. Are you under the influence of alcohol or drugs?
9. Are you in good physical and mental health?

MEDICAL CONDITIONS & INFORMED CONSENT: (To be completed by the client) Please answer **YES** or **NO** to all the following questions. These details will then be discussed (in confidence) with your Plasma Pen specialist.

1. Do you feel fit, well and informed enough to have the Plasma Pen procedure today?

2. Are you aware that, post-treatment, you may not look your best for the next few days and that you may potentially also experience some minor discomfort, redness and swelling?

ALLERGIES

1. Do you have any allergies or have you ever experienced allergic reactions to any kinds of medicines, foods or products like latex gloves, plasters etc.? If so, please list:

2. Do you or have you ever suffered an allergic reaction to any local/topical anaesthetics?

MEDICINES, MEDICAL TREATMENT & MEDICAL CONDITIONS

1. Are you currently undergoing any medical treatment and/or have you received any medical treatment within the last 6 months? If so, please list:

2. Are you currently taking any medication? If so, please list what medication you are taking and for what condition. This should include any remedies that you are buying over the counter as well as any prescribed medicines:

3. Do you knowingly suffer from any infectious diseases or any other acute or chronic diseases? If so, please list:

4. Do you suffer from uncontrolled, high or low blood pressure? Do you have any other kind of circulatory issues or deficiencies including Ischemic Tissue and Thrombosis?

5. Do you suffer from epilepsy, dizziness, fainting attacks or any other seizure related condition? If so please list:

6. Are you taking any Anticoagulants (blood thinning medication) such as Warfarin, Apixaban, Dabigatran, Edoxaban, Rivaroxaban?

7. Do you suffer from an auto-immune disease such as Lupus, MS, Scleroderma, Shingles, Psoriasis etc.? If so, please list:

8. Do you suffer from diabetes? If so, please state if controlled:

9. Do you have any respiratory problems such as Asthma or pulmonary problems like Emphysema, COPD or Bronchitis? If so, please list:

10. Do you have any heart problems or conditions? Do you have angina? Do you have a pacemaker? Do you have any other cardiovascular condition?

11. Do you suffer from Haemophilia or any other type of blood disorder such as Anaemia, Thalassemia, Polycythemia, Leukemia, Lymphoma, MDS, Myeloma and Thrombocythemia? If so please list:

12. Do you suffer from kidney and/or liver disease?

13. Do you have any history of malignant cancer? If yes, have you had any radiation or chemotherapy treatment and, if so, when?

14. Have you ever had an organ transplant?

15. Do you suffer from HIV/AIDS?

16. Do you suffer from Hepatitis?

17. Do you suffer from Herpes Simplex (commonly referred to as cold sores)?

YOUR SKIN & SKIN CONDITIONS

1. Do you suffer with any skin conditions e.g. Rosacea, Erysipelas, Eczema, Impetigo, Scabies etc.? If so, please list:

2. Do you currently have or have you ever been treated for any pigmentation disorders such as Melasma, Age Spots, Hyperpigmentation, Vitilago, Solar Lentigines etc.? Do you ever develop dark spots on the skin from wounds?

3. Are you taking or have you applied any oral/topical steroids or corticosteroids in the last 6 months? This would include medication such as Accutane for Acne and Hydrocortisone for Eczema.

4. Do you suffer from, or have any problems with scars healing? Do you suffer from keloid scarring, hypertrophic scarring or any other type of scarring? If so, please list:

5. Do you bruise or scar easily from minor skin injuries and/or do you bleed excessively from minor cuts? Have you ever experienced a Haemorrhage?

6. Is you skin oily and/or do you have large skin pores?

7. Do you regularly use Retinol-A, Glycol or any other exfoliating product?

RECENT TREATMENTS

1. Do you have, or are you planning to have any botox, fillers, laser treatment, chemical peels or plastic surgery in the near future? Have you had any in the last 3 months? If so please list/state:

2. Have you ever had any recent Permanent Make Up (PMU) or cosmetic treatment? If so when and did you experience any problems healing?

3. Have you had Laser Eye Surgery in the last 3 months?

OTHER/VARIOUS

1. Do you wear contact lenses?

2. Do you have any major visual impairment and/or do you suffer from Glaucoma, Cataracts, Dry Eye, Styes/Conjunctivitis or Frequent Eye Infections? Do you have any corneal abrasion or retinal detachment? If so, please list:

3. Do you have any prosthetic implants or any plates or pins in the area being treated by Plasma Pen?

4. Do you have any imminent holiday plans? When was your last time in the sun? Please elaborate:

5. Is there any other ailment or reason you feel we should know about which could prevent us from delivering your Plasma Pen treatment?

6. If you suffer from any of the medical conditions listed then it is very important that you notify your specialist who can take all the necessary precautions to ensure you receive the best Plasma Pen treatment and you avoid any potential risks to your health or wellbeing.

Notes to discuss:

I confirm I have fully read, understood and completed this Medical Conditions and Informed Consent Form and that the procedure known as Plasma Pen by Louise Walsh International has been fully explained to me. I have had the opportunity to ask questions about the treatment and that my questions have been answered. I understand the importance of fully revealing my accurate and complete medical history and I confirm that I have been candid in my answers. I understand that withholding any medical information may be detrimental to my health and safety both during and after my procedure and I confirm that I have not withheld any medical information. I understand that if there is any change in my medical history it is my responsibility to inform my technician. I understand that for the desired outcome; several treatments may be required and this has been explained to me. I also understand there is no guarantee and no guarantee has been given as to what the outcome of treatment may or may not be. By my signature I affirm that I am at least 18 years old and freely give my informed consent to receiving treatment.

CLIENT SIGNATURE

THE FITZPATRICK SCALE - YOUR SKIN TYPE: (To be read in full and completed by the client)

The Fitzpatrick Skin Type is a skin classification system. Skin Types range from very fair (Type I) to very dark (Type VI). Only skin types I, II and III on this scale can safely be treated with Plasma Pen as people with darker skins have melanocytes capable of making large amounts of melanin. When dark/black skin is injured (i.e. through the micro-trauma created by Plasma Pen), these melanocytes can hyperpigment or hypopigment. This is because a combination of the inflammatory response and ultraviolet causes the inflammation to disrupt the basal cell layer. Melanin pigment is then released but subsequently it can become trapped by macrophages in the papillary layer. Once the wound healing has completed and the junction repaired the melanin pigment granules can get caught within the dermal layer with no way of escape which can cause pigmentation issues. If you have Indian or African ancestry it is unlikely your technician will be able to treat you safely.

If you have spent time in the sun recently you may temporarily present as darker than your true skin type. If so you should at the very least delay your Plasma Pen procedure and stay out of the sun until your skin returns to a treatable skin type in the area where you desire treatment.

I, the Plasma Pen Elite Technician, confirm that I have checked the client's current Skin Type which is as follows (please circle):

SKIN TYPE: I II III IV V VI **TECHNICIAN SIGNATURE:** **DATE:**

FITZPATRICK SKIN TYPE TEST - CLIENT AGREEMENT

I, the client, have read and understood all the information about Skin Types prior to my treatment. I agree with all points discussed. I am aware that hyperpigmentation or hypopigmentation is a very real possibility for Skin Types IV and above and that I should not undergo plasma treatment if I present above Skin Type III in the area to be treated on the day of my procedure.

PLASMA PEN TREATMENT PLAN:

This part of the consultation record is to be completed by your specialist in order to record important elements of your treatment. This form will be kept with your Medical and Consent forms. THIS FORM MUST BE USED TO RECORD THE TREATMENT OF ONE AREA ONLY. All other treatments must/will be recorded on separate treatment plan forms.

Treatment area(s) being completed:

Number of treatments recommended:

Treatment number: Please circle (only 4 treatments allowed per 1 area)

1st 2nd 3rd 4th

Fitzpatrick Skin Type: Please circle (Plasma Pen treatment is not allowed on Type IV, V or VI)

TYPE I TYPE II TYPE III TYPE IV TYPE V TYPE VI

For first visit only: Following consultation with your client, what is the agreed treatment plan and how many visits will it likely take to achieve?

What is the predicted outcome of treatment and your recommendations?

For 2nd and subsequent visits: Client must re-consent using the form area below

Were your expectations met?

Did the area heal as described?

What is the agreed objective for today's procedure?

What is the predicted outcome and recommendations?

Describe the treatment area including a description of the appearance of the skin:

CLIENT SIGNATURE: **TECHNICIAN SIGNATURE:**

PLASMA PEN TREATMENT AGREEMENT

I, the Plasma Pen Elite Technician, confirm that I have carefully checked all the paperwork including consent forms and medical history. I have discussed all points of the procedure with my client and they understand all elements of their treatment. Aftercare advice has been presented to the client who has fully understood them and a printed copy will be provided.

TECHNICIAN SIGNATURE: **DATE:**

Please ask your client to read, understand and sign the following prior to their treatment:

I, the client, agree with all points listed and discussed, and I wish to proceed as recorded. I participated fully in the decision for the selected area or areas intended for my Plasma Pen treatment. I hereby agree to follow all the aftercare advice provided.

CLIENT SIGNATURE: **DATE:**

RECORDED DOCUMENTATION:

Treatment area(s):

Any other treatments on this day:

Probe Used: Lot / Expiry:

Anaesthetic Used: Lot / Expiry:

Photographic Evidence:

Fitzpatrick scale:

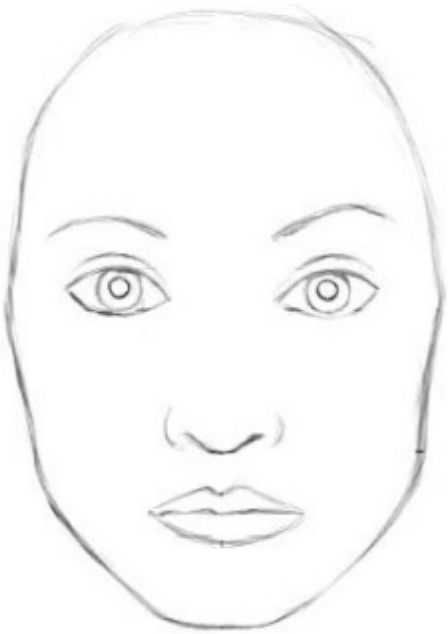
Tolerance Level (1 Lowest 10 Highest):

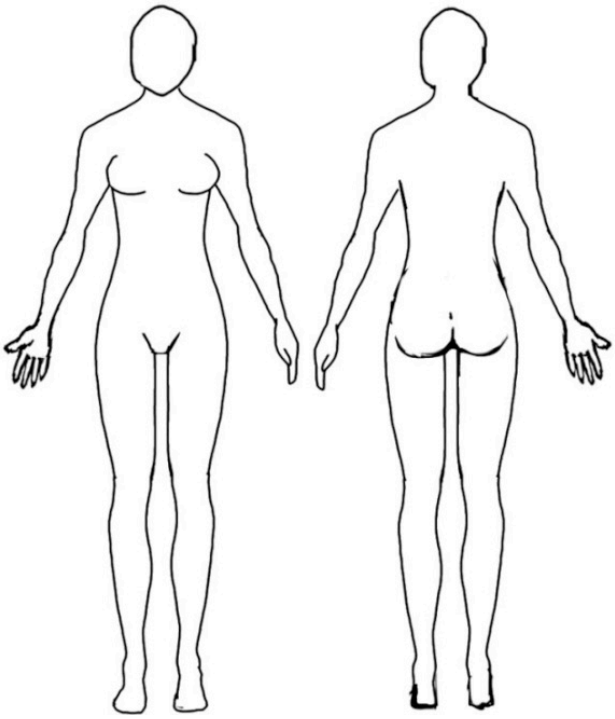
Were any other people present?

NOTES: Please record any relevant comments below which were made by the client and/or made to the client after the procedure and information relating to further treatments required:

MY PLASMA PEN PROCEDURE: To be completed by the client at the end of the procedure:

Areas treated (please circle):





My procedure has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns about my treatment with my specialist technician.

I fully understand the aftercare instructions and I have been provided with an aftercare advice sheet which I commit to follow for my own benefit. If/where relevant, I have been provided with aftercare product.

CLIENT SIGNATURE: **TECHNICIAN SIGNATURE:**

DATE:

FOOTNOTES: