Patient Information and Consent Form
Platelet Rich Plasma
Consent for blood draw only

Description of treatment:
This treatment involves the collection of your blood (approximately 8 – 16ml), then your blood is spun down using a centrifuge to separate out the plasma and platelet portion using the separator gel' as a special filter. The PRP portion of your blood is then injected back into your skin to stimulate new collagen production, and to re-energise your cells into rejuvenating themselves. The product injected is 100% your own blood by-product (autologous).

If you have any questions please do not hesitate to ask your physician or nurse.

Mr / Mrs / Ms / other:
First name:
Surname:
Address:

Emergency Contact Name: ...
Contact number:
.. Relationship to person:
.. Pre-testing done, if any?
. Blood tests: Full blood count Yes / No
. Pain relief option chosen:

Tel home:
Tel work:
Mobile:

.., Topical applied at:
Removed at:

Email:
Date of birth: / /

.. Area/s to be treated today:
Occupation:
.. Amount of Plasma made: ml
Previous surgical and non-surgical facial Placement notes:

Cosmetic procedures: NA

Contraindications:

You should not have PRP treatment done if you have any of the following conditions: NA
Skin conditions and diseases including: Facial cancer, past and present. This includes SCC, BCC and melanoma, systemic cancer, chemotherapy, steroid therapy, dermatological diseases affecting the face (i.e. Porphyria), Blood disorders and platelet abnormalities, Anticoagulation therapy (i.e.: Warfarin)
Comments:

If you are unsure about any of above mentioned conditions, please ask!

Have you ever been told that you suffer from or suspect you suffer from: Platelet dysfunction syndrome, critical thrombocytopenia, hypofibrinogenaemia, haemodynamic instability, sepsis, chronic liver disease, Hepatitis or any acute or chronic infections? **YES / NO** *(circle one)* NA
If yes, please state:

Are you currently taking any of the following medications: Aspirin, Anti-inflammatory such as Nurofen, Votaren, Diclofenac, or Naproxen etc.? St Johns Wort, Garlic, Vitamin E **YES / NO** *(circle one)*
If yes, please state which one/s and last date taken: NA

Are you currently taking, or have you recently taken (within 14 days) Vitamin E, or Fish Oil supplements that could have a thinning effect on your blood?
YES / NO *(circle one)* If yes, please state: NA

SIDE EFFECTS: you will likely experience mild to moderate swelling of the treated area, this will last for about 12- 24 hours; ice or cold compresses can be applied to reduce swelling if required. You may notice a tingling sensation while the cells are being activated. In rare cases skin infection may occur, which is easily treated with an anti-biotic

Client Consent

I understand that *due to the natural variation in quality of Platelet rich plasma, results will vary between individuals.*
I understand that although I may see a change after my first treatment; I may require a series of up to 6 sessions to obtain my desired outcome.

The procedure and side effects has been explained to me including alternative methods; as have the advantages and disadvantages.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment.
I am aware that the PRP treatment is not permanent as natural degradation will occur over time.
I authorize NA .to perform the injection of PRP (Platelet Rich Plasma) for rejuvenation.

This consent form will be valid for up to 6 applications of PRP, after which time I may be asked to compete a new form.
I state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it.

I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled in prior to my signature.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.
When completing the medical questionnaire, I have answered the personal medical history questions fully and to the best of my ability.

Name

Signature X _____

Date

Clinic Name: Tampa Eye Clinic - Dr Scheiner .