

Initial Consultation Notes

Name of Patient Date

Address

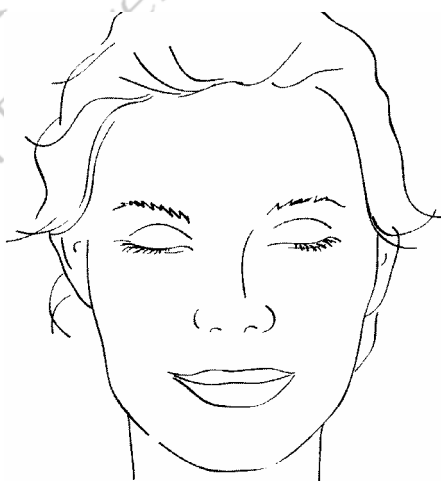
Date of Birth

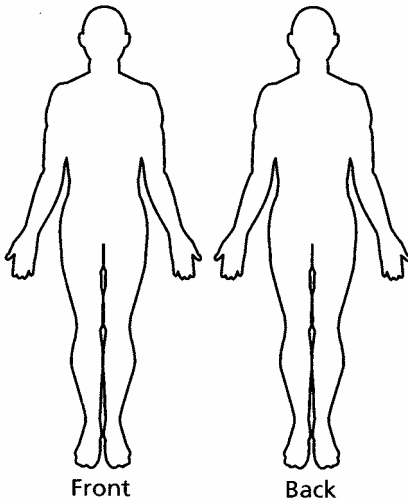
Telephone Number Mobile Telephone Number Email

How did you hear about Dermis Deep?

GP Name & Address

Current Condition requiring treatment:

Face:


Other Areas:

Front Back

Consultation Notes

Past Cosmetic Tx

Patient Expectations

Skin Type (e.g. oily, dry, sensitive, acne, sun-damaged)..... Fitzpatrick =

Current Skin Regime

Name of Patient

Date

Past Medical History

Please answer all the following questions:

1. Are you currently receiving treatment from a specialist? (Y/N) (If yes, please give details)

.....

2. Have you suffered from any of the following? (If yes, please provide full details below)

	Yes	No
Cardiac or Cardiovascular Disorders (e.g. Angina, MI, H/T, etc)		
Respiratory Disorders (e.g. Asthma, COPD)		
Gastrointestinal Disorders (e.g. Inflammatory Bowel Disease, etc)		
Liver Disease or Disorders		
Neurological Disorders (e.g. Epilepsy)		
Musculoskeletal Disorders (e.g. Rheumatoid or Osteoarthritis)		
Malignancies (e.g. skin cancer, etc)		
Any illness or medical condition not specified above		

.....

3. What operations or invasive procedures have you had in the past?

.....

4. Are you presently taking any medication or undergoing any treatment? (Y/N) (If yes, please give details)

.....

5. Do you have any drug allergies? (Y/N) (If yes, please give details)

.....

6. Will there be anybody at home with you later on who could call for help should you feel unwell? (Y/N)

DERMAL FILLER TREATMENT NOTES



Name of Patient

Date

Practitioner =

DO NOT GIVE TREATMENT IF PATIENT ANSWERS YES TO ANY OF THE FOLLOWING:

DERMAL FILLERS	Yes	No
1. Pregnancy or Breastfeeding		
2. History of allergy, intolerance or anaphylaxis to previous dermal fillers		
3. Presence of permanent implants close to region to be injected		
4. Laser skin resurfacing or skin peels within last 6 weeks		
5. Roaccutane usage within past 12 months		
6. Bleeding disorders		
7. Anticoagulant therapy		
8. Local infection(eg active acne, herpes) close to region to be injected		
9. Unrealistic expectations, excessively anxious, lack of co-operation (eg, needle phobia)		

Details of previous dermal filler administration:

.....
.....
.....

Consent Form Signed (Y/N)


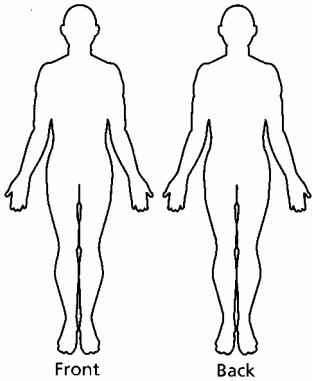
Preop Frontal/Side/Oblique Photos Taken (Y/N)

Name of Patient

Date

Details of Dermal Filler Administered

Anaesthesia =

	Area – Please specify	Product Type	Amount (ml or units)	Lot Number
				
 <p>Front Back</p>				

Post treatment Checklist handed over (Y/N)

Date given for 2wk follow-up:

Invoice filled in (Y/N)


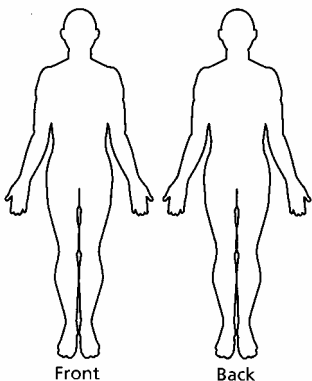
2 WK FOLLOW UP APPOINTMENT

Name of Patient _____ Date _____

Seen by (Name of Practitioner)

Patient Feedback

Details of any top-up required:

	Area – Please specify	Product Type	Amount (ml or units)	Lot Number
				
 <p>Front Back</p>				

Postop Frontal/Side/Oblique Photos Taken (Y/N)

Next recommended appointment (approx 6mths for dermal filler)

Name of Patient

Date

Consent Form for Dermal Filler Treatment

Proposed treatment

.....

I confirm that I have received information regarding the product's contra-indications and potential side effects:

Contraindications: You cannot receive Dermal Fillers if you are in the following categories :

1. Pregnant or Breast Feeding
2. History of allergy, intolerance or anaphylaxis to previous dermal fillers
3. Presence of permanent implants close to region to be injected
4. Laser skin resurfacing or skin peels within last 6 weeks
5. Roaccutane usage within past 12 months
6. Blood Coagulation Disorders or taking anticoagulants in the last week.
7. Local infection(eg active acne, herpes) close to region to be injected
8. Local Infection at injection site
9. Unrealistic expectations

Potential Side Effects

1. Bruising, swelling, redness, infection at injection site
2. Associated stinging, itching or discomfort upon pressure at the injection site
3. Rarely discoloration at the injection site or visibility of injectable material
4. Cold sore eruption
5. Lumps, nodules or unevenness
6. Injection into blood vessels, occasionally necrosis, abscess or granuloma formation
7. Allergic reactions & Local anaesthetic toxicity
8. Limitation of treatment & likely duration of results

All foreseeable risks of Dermal Filler therapy listed above have been thoroughly explained to me. My questions regarding the treatment procedure, its potential side effects and contraindications were answered to my full satisfaction. I understand that the effects of Dermal Fillers lasts for an average of 6-12 months but will vary depending on the condition of the skin, area treated and lifestyle factors such as sun exposure and smoking. I also had adequate time to consider my decision. The average life treatment in the lips is 6 months due to the high vascularisation and action of the lip area. A touch-up procedure may be required for 1-3 weeks after the first injection to help optimise the results. I understand that I am free to revoke my consent at any time.

I consent to the administration of Dermal Filler and have been given after care instructions. I also consent to the taking of photographs. This consent form is also signed for future administration of Dermal Filler.

Patient Signature

Date

Practitioner Signature

Date

Name of Patient

Date

Aftercare Advice following Dermal Filler treatment

WHAT SHOULD I BEAR IN MIND AFTER MY TREATMENT?

- **Immediately after treatment, there may be slight redness, swelling, tenderness and an itching sensation in the treated area. This is a normal result of the injection. The inconvenience is temporary and generally disappears in a few days. Please contact us for advice if the inconvenience continues or if other reactions occur.**
- **The initial swelling after lip treatment may last longer. Some patients experience swelling for about a week and the lips can look somewhat uneven during this time. This means that the result directly after the treatment should not be seen as the final result.**
- **Avoid touching the treated area 6 hours after the treatment. After that the area can be gently washed with soap and water. Light make-up may then be applied.**
- **Until the initial swelling and redness have resolved, do not expose the treated area to intense heat (e.g. solarium and sunbathing) or extreme cold.**
- **If you have previously suffered from facial cold sores, there is a risk that the needle punctures could contribute to another eruption of cold sores.**
- **If you are using aspirin or any similar medication, be aware that these may increase the bruising and bleeding at the injection site.**

HOW LONG WILL A TREATMENT LAST?

- **Dermal Fillers are long lasting but not permanent. You always have a choice to continue or change the combination of treatments – and the procedure can be repeated as often as you like.**
- **Most patients choose to have a follow-up treatment 6 to 12 months after an initial treatment of wrinkles. When the lips have been treated a follow-up treatment is normally needed after about 6 months.**
- **A touch-up treatment within 2 to 4 weeks after the initial treatment may be necessary to achieve an optimal correction.**

PLEASE DO NOT HESITATE TO CONTACT US IF YOU HAVE ANY CONCERNS

Practitioner Contact Number =

Date of next appointment =