CE mark Approved

Plasma Pen
BY LOUISE WALSH INTERNATIONAL

PLASMA PEN CONSULTATION & CONSENT RECORD

CLIENT FIRST & LAST NAME:

_____

PLASMAPENBYLOUISEWALSHINTERNATIONAL

855.568.3776 USA Headquarters

YOUR PLASMA PEN SPECIALIST PROVIDER:

TECHNICIAN NAME: _____

YOUR PLASMA PEN CONSULTATION RECORD

Plasma Pen is a procedure that can only be performed by a specifically trained and qualified specialist technician 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 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:

1. You have chosen an elective cosmetic procedure that is not medically necessary
2. “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
3. Some results can be cumulative for optimal effects to be achieved and you may 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
4. Depending upon the area of your treatment, additional treatments cannot usually be performed 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
5. 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 in your consultation record.

6. The skin type of every client is different and the healing process may in rare cases lead to some discoloration 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
7. 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
8. During your treatment you may experience some minor discomfort depending on the area being treated. Your specialist will reassure you throughout to make you feel comfortable
9. Since the treatment includes controlled micro traumas to the skin, you may experience the smell of plasma reacting with the skin surface during your treatment. This is perfectly normal
10. 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
11. Please be aware that any subsequent skin altering procedures such as plastic surgery, implants, injectables and weight gain may alter the Plasma Pen look

Client Signature: **Date:**

TO BE COMPLETED BY THE CLIENT:

MEDICAL HISTORY

Name: _____ Date _____

Address _____ Tel # _____

Birth Date _____ Male _____ Female _____ Email: _____

Have you had in the past or do you currently have:

Epilepsy, dizziness or seizure related issues	Y N	ANY Autoimmune disease (Lupus, MS, etc).	Y N
Diabetes	Y N	Asthma, COPD , Emphysema, lung issues	Y N
Heart Disease(pacemaker)	Y N	Hemophilia or other blood disorders	Y N
Kidney/liver disease	Y N	Malignant cancer if so what and when	Y N
Organ Transplant	Y N	HIV/AIDS	Y N
Hepatitis	Y N	Alopecia	Y N
Anemia	Y N	Shingles(less than 6 months)	Y N
Keloid scars	Y N	Blood thinners	Y N
Laser Eye surgery (within 3 months)	Y N	Pigmentary issues hyper/hypo	Y N
Herpes Simplex (cold sores)	Y N	Issues healing	Y N
Skin condition(eczema,rosacea,etc)	Y N	Vitiligo	Y N
Gold therapy	Y N	Taken Accutane (within 6 months).	Y N
Cataracts	Y N	Contact lenses	Y N
Thyroid issues	Y N	Herpes Simplex (cold sores)?	Y N

Any health concerns not listed above or ailment you feel we should know about which could prevent safe and effective treatments? If so, please list

_____

List any and all medication you are currently taking, including herbs and vitamins, cannabinoids, anti-depressants, etc.

_____

Do you have birth marks, port wine stains or cosmetic tattoos on the area you are looking to treat? Y N

Any allergies to topical anesthetics or latex? Y N

Are you pregnant or breast feeding? Y N

Have you ever been diagnosed with Trichotillomania? Y N

Have you had Eye Surgery (laser or other) in the last 3 months? Y N

Do you have any respiratory problems such as Asthma or pulmonary problems like Emphysema, COPD or Bronchitis?

If so, please list: _____

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.

If so, please list: _____

Do you have any major visual impairment and/or do you suffer from Glaucoma, Cataracts, Dry Eye, Stye/Conjunctivitis or Frequent Eye Infections? Do you have any corneal abrasion or retinal detachment?

If so, please list: _____

Are you currently under the care of a physician? If so, for what? Y N

_____]_____

Have you had any recent sun exposure/Tanning beds/Creams/ Spray Tans? Y N

If so…when?

_____

Do you have any imminent vacation plans where you will be exposed to sun? Y N

If so…when?

_____

Do you use sunscreen? _____ What SPF? _____ Do you scar easily? _____ Do you heal quickly? _____

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: _____

Do you regularly use Retinol-A, Glycol or any other exfoliating product? Y N

Have you received any skin tightening treatment before? Y N

If YES please answer the following questions:

How long ago was your treatment? _____

What procedure did you received? _____

I certify that the preceding medical and personal statements are true and correct. I am aware that it is my responsibility to inform the technician and any staff at _____ (Practice Name) of my current medical health and to update them in the event of any changes.

Client Signature _____ Date _____

I, _____ (patient name) Hereby authorize _____ (technician name), to perform Fibro-blasting with the Plasma Pen on me. I understand that this procedure works on promoting skin tightening, lifting and rejuvenation by creating microtraumas to promote new collagen. I understand that multiple treatments may be needed and in rare cases no improvement may be seen.

I am aware of the possible experience and or risks:

1. DISCOMFORT – some will be felt, varies patient to patient and area to area. _____**(initial)**
2. MILD TO MODERATE SWELLING – especially around the eyes and in the periorbital area. _____**(initial)**
3. STINGING SENSATION - for about an hour after treatment. _____ **(initial)**
4. TINY CRUSTS - form on the area treated and usually linger for 5-7 days. _____ **(initial)**
5. DO NOT PICK CRUSTS - This could cause scarring. _____ **(initial)**
6. AVOID SHAVING - in the area treated until all healing has taken place. _____ **(initial)**
7. AVOID HEAT FOR 3-4 DAYS (hot showers, exercise, etc.) _____ **(initial)**
8. NO SMOKING – this will hinder the healing process. _____ **(initial)**
9. IF POSSIBLE, TAKE VITAMIN C – it helps to boost your immune system. _____ *(***initial)**

10. PRE AND POST CARE – I understand that I must comply with recommended pre and post care and following it is crucial for the healing, preventing infection and results of treatment. _____ **(initial)**

11. NO GUARANTEES – I understand that there are no guarantees and refunds will NOT be given. _____ **(initial)**

12. Hyperpigmentation – As a possible adverse reaction, I understand there is a risk of post treatment Hyperpigmentation. This would most likely be due to exposure of the area to UV light while the long-term healing process is taking place or the healing reaction of a client's skin. I understand I should use **SPF40 sun protection** for at least 12 to 20 weeks (from once the skin has healed several days after the initial treatment) as part of my **aftercare** program. _____ **(initial)**

13. Pink Atrophic spots (where the dots/spots were applied by Plasma Device) can last up to 6 months after treatment although this is **incredibly rare**. It is not completely clear what causes this long-term adverse reaction but, so far, this has ultimately subsided on its own in the long-term. It could be due to the use of make-up, other inappropriate products and/or poor personal aftercare during the short-term healing process. As a possible adverse reaction, I understand this is very rare but there is risk of this occurring after treatment. _____ **(initial)**

I attest that the following points have been made to me:

- The potential benefits of proposed treatments.
- The possible alternate procedures.
- The probability of success
- The most likely complications and risks involved with proposed treatments and healing period.

Photographic documentation will be taken. I hereby grant _____

___ (Technician Name) consent to take photographs BEFORE, DURING and AFTER my Plasma Pen procedure. I agree to these being stored with my case file and for technician to use such photographs for the purpose of marketing and advertising unless otherwise indicated.

My questions regarding this procedure have all been answered to my satisfaction I understand the procedure and accept the risks. I hereby release _____ (Technician Name) and all affiliated with _____ (Practice Name) from all liabilities associated with the above indicated procedure throughout the treatment process.

No guarantee, warranty, or assurance has been made to me as the results that may be obtained. I am aware that additional treatments may be necessary for desired results. Clinical results vary patient to patient, and I understand that. I agree to adhere to all safety precautions, pre and post care during treatments. I understand all payments are non-refundable.

ACKNOWLEDGEMENT: BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THE PERMISSION FORM FOR PLASMA PEN TREATMENTS AND THAT THE DISCLOSED HEREIN WERE MADE TO ME

_____ _____ _____

Client Signature Print Name Date

TREATMENT LOG

Name
_____

Area(s) treated: Recommended # of TXS Price paid

_____ _____ _____

Skin Fitzpatrick Type _____ Date of last sun in area treated _____

Topical Anesthetic used/amount of time _____ Pronox Y N

Photos Takes Y N Health history/Consent signed? Y N

Probe used? _____ Pain scale 1 -1 0 _____

Treatment notes:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Technician Signature Date