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| **CRYOPEN MEDICAL CONSENT FORM** | |
| **Please complete all questions as accurately as possible** | |
| FULL NAME |  |
| ADDRESS (including postcode) |  |
|  |  |
|  |  |
| MOBILE NUMBER |  |
| LANDLINE NUMBER |  |
| EMAIL ADDRESS |  |
| DATE OF BIRTH |  |
| DRs NAME AND SURGERY |  |

**IMPORTANT INFORMATION ABOUT CRYOPEN TREATMENT**

Cryopen creates a histamine reaction which stings and may last for 10 minutes or so. The area my look darker, red, and inflamed. It is quite common that the area may blister. Blistering may last for a few hours up to a few days. If it does pop. Gently dry and use a little Germolene or Savlon cream twice a day to help prevent infection. The same applies if a scab should be knocked off. If the treated area for any lesion becomes tender, a little Germolene or Savlon will ease the area.

**DO NOT**

* Pop blisters, they will go down on their own.
* Pick at the treated area. This may cause scarring and will take longer to heal. It can also become infected.

**Lesion healing process**

* Skin tags- These will turn black and will fall off between one to six weeks
* Larger skin tags (over 3mm) may need a second treatment.
* Warts/ veruccae - These usually need more than one treatment. Re- treatment can be after 4 weeks.
* They will turn black indicating cell death in the treated area.

**Milia** - These are superficial keratin filled epidermal cysts that will flatten and disappear. However, if prone to milia, new ones may reform at any time.

**Pigmentation/cherry angiomas** - The treated area may become raised and inflamed. Over the next 24 hours the area will darken and form a crust on the surface. Don’t pick it! When it naturally falls off the skin will be shiny pink baby skin which will re-pigment over the following weeks.

**General healing expectations** - If a crust has not fallen off after 4 weeks, just wait as some skin takes longer to regenerate.

If treated skin is tanned, treatment will remove tan and skin will re-pigment to your natural colour

**PRE AND POST TREATMENT CARE**

* Please do not wear makeup on day of treatment.
* Please do not take blood thinners (unless medically prescribed) 24 hrs prior to treatment.
* Please avoid alcohol 24 hours prior to treatment.
* Do not touch treated area for four hours
* Remain upright for four hours. Do not lie down or incline head, e.g. gardening
* Avoid alcohol for four hours
* Avoid exercise for four hours
* Avoid saunas, hot tubs and sunbeds for 24 hours
* Avoid skin peels and laser treatments for two weeks
* Avoid sunlight. Wear minimum 30 SPF. Apply twice daily.
* Avoid heavy physical exercise for seven days.
* The full effects will be after 14 days.
* You may start to see a difference after seven days.

**PLEASE TYPE ‘Y’ NEXT TO ANY MEDICAL CONDITION(S) YOU HAVE OR HAVE HAD**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Amyotrophic lateral sclerosis |  | Angina |  | Asthma |  | Autoimmune disease |  | Bells Palsy |  |
| Bleed or bruise easily |  | Blood borne diseases |  | Blood pressure (high or low) |  | Cancer |  | Circulatory disease |  |
| Cold sores |  | Crohn's disease |  | Diabetes |  | Eaton-Lambert syndrome |  | Eczema |  |
| Endocrine/ Thyroid |  | Epilepsy |  | Heart disease |  | Hepatitis |  | Implants |  |
| Jaundice |  | Kidney disease |  | Liver disease |  | Lupus |  | M.S. Chorea |  |
| Multiple sclerosis |  | Myasthenia Gravis |  | Psoriasis |  | Recent vaccinations |  | Rheumatoid Arthritis |  |
| Steroids |  | Stroke |  | Varicose veins |  | Are you pregnant |  | Are you breast feeding |  |
| Any other medical treatment not listed |  | Are you currently / recently taking / taken any prescription drugs |  | Are you currently / recently taking / taken any other drugs / supplements |  | Do you have any drug allergies |  | Have you recently had surgery |  |
| Have you recently had any X-rays taken |  | None of these |  | Any other medical condition (please add in space provided) |  | | | | |

**PLEASE TYPE ‘Y’ NEXT TO ANY TREATMENTS(S) YOU HAVE HAD**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Botox (Botulinum Toxin) |  | Dermal Fillers | |  | PDO Threads |  | None of the above |  |
| Please add details of any other treatments in space provided | | |  | | | | | |
| Please advise of any adverse effects from treatments received | | |  | | | | | |

**PLEASE TYPE ‘Y’ NEXT TO ANY ALLERGIES YOU HAVE**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Collagen products |  | Lidocaine (Dentist’s numbing injections) | |  | Painkillers |  | Anaesthetic creams |  | None of the above |  |
| Please advise of any other allergies you have | | |  | | | | | | | |

**MEDICAL CONSENT AND DELCARATION FORM FOR TREATMENT**

The information I have given is correct to the best of my knowledge. I have not knowingly withheld any medical or surgical information. I agree to inform my practitioner of any health or medication in the future. I can withdraw my consent in writing to treatment up to and after the start of treatment providing it is safe and practical to stop treatment. I have read and understood the notes on Chaelis Aesthetics Clinic’s obligations under the Data Protection act 1998 and GPDR as of 25th May 2018. I understand and fully accept the use of lidocaine, should it be necessary by injection or topical application for pain management and I am aware the risk of reaction is possible and will be patch tested. I understand there are no guarantees or assurances as to the final result that may be obtained and that any issues that need to be addressed or rectified will be done within reasonable time and there may be a charge for this. I agree to the use of, if necessary, the use of topical anaesthetic cream. If necessary, the use of Lidocaine injections. Anonymised before/after photos for insurance and/or promotional purposes. For my GP to be contacted and information shared in an emergency. For my next of kin to be contacted and information to be shared in an emergency.

**By submitting these forms, you agree that all the information is true and accurate**

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| --- | --- |
| **I AGREE (Please type ‘YES’ in space provided)** |  |

**RELEASE FORM AND GDPR CONSENT**

I certify that the consultation statements I have given are true and correct and that I, having been advised by Lesley Spencer, completely understand the implications of the treatment I will be receiving including the listed side effects and at no time have I been misled or badly informed by the above mentioned practitioner or company. Any falsifications of information submitted by myself could be detrimental to my health and success of my treatment and may cause me to experience possible discomfort. I hereby authorize and direct the company and the practitioner to administer the prescribed process and perform such procedures as may be deemed necessary and advisable. My signature below constitutes my acknowledgement that (1) I have read, understood and fully agree to the forgoing. I further understand that I have a seven-day cooling off period. (2) I give consent to the proposed treatment process that has been satisfactorily explained to me and I have all the information I desire (3) give my consent and authorization voluntarily and release the establishment and it’s agents of any claims that I have or may have in the future in connection with the treatment. (4) I understand that the results may not be up to my expectations. (5) I understand that more than one treatment may be necessary. (6) I have received, read and understood pre and post care instructions. (7) We take your privacy seriously. We will only use your personal information to provide you with aesthetic care related services, including appointment, recording and processing your information relevant to your aesthetic treatment and care and medical conditions. Where necessary we may share your information with third parties such as your doctor and the NHS and your next-of-kin. Additionally, we may also contact you with details of other treatments and services we provide.

**PLEASE TYPE ‘Y’ NEXT TO YOUR PREFERENCES**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TELEPHONE** |  | **TEXT/SMS** |  | **EMAIL** |  | **POST** |  | **ANY** |  |

**By submitting these forms, you agree that all the information is true and accurate**

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| --- | --- |
| **I AGREE (Please type ‘YES’ in space provided)** |  |
| **SIGNATURE (Please type your full name to act as your signature in space provided)** |  |
| **DATE** |  |