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| **VITAMIN B12 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 VITAMIN B12 TREATMENT**

**IM injections and IV drips are prescription only medicines and have to be ordered at least ONE WEEK PRIOR TO TREATMENT.**

**You have to fill in this medical consent forms and pay for your treatment(s), (single treatments, or the full course) and book in order for us to process your prescription. Thank you for your co-operation in this.**

**Vitamin B12 (cobalamin)**

**Vit B12 is necessary for red blood cell formation, neurological function and DNA synthesis.**

**Benefits:-**

**Vegetarians, Vegans, May aid weight loss, Increases metabolism, Anaemia, Depression**

**May improve mood and depression (It is needed in the formation of serotonin)**

**Support for older adults**

**Gastrointestinal disorders such as Crohn’s or coeliac disease**

**Gastrointestinal surgeries such as bariatric surgery or bowel resection**

**Those who take metformin for blood sugar control**

**Those who take proton pump medication for chronic heartburn**

**Pernicious anaemia, Digestive issues such as IBD, Poor focus, Poor memory**

**Hypothyroidism, Muscle tension and tingling limbs, Neuropathy**

**Contraindications**

**Cold or allergy symptoms affecting the nose, Kidney or Liver disease**

**Iron or folic acid deficiency, Any type of infection**

**Medication or treatment affecting bone marrow**

**Leber’s disease, Allergy to cobalamins**

**Planning to become or are pregnant, Breast feeding**

**Treatment time 30 minutes to one hour**

**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 tr0eatment 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**

|  |  |
| --- | --- |
| **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**

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

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

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