Dermaroller™ Patient / Client Consent Form

Patient / Client Details	
Name	
DoB	
Address	
Post Code	
Email	
Telephone	

I am voluntarily consenting to a Dermaroller™ procedure of the skin.

I understand that the procedure can result in an appearance enhancement and is typically used for skin rejuvenation and scar repair and that the treatment uses Dermaroller™ medical device that creates controlled micro-surgical needle punctures of the skin surface. I also understand that I may require a series of Dermaroller™ treatments, normally with at least 6 weeks between procedures, t achieve the maximum cosmetic result. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me regarding the outcome of the procedure.

I understand the following:
That immediately after the Dermaroller™ procedure the skin will be red, resembling moderate sunburn, as the skin naturally heals the redness will resolve. The skin may remain red for three or four days after the Dermaroller™ treatment, although it is usual for it to subside within two days and many people are able to return to their normal activities the same or next day. It is recommended that the use of soaps on the treated skin area is restricted until the redness subsides and where possible warm/tepid water and/or gentle skin cleansers are used for cleansing.
There is a small risk of infection of the treated skin area after the Dermaroller™ procedure although this is not expected to occur due to the sterility of the Dermaroller™ medical device and the fact that the epidermis of the skin is not removed as a result of the procedure.
The Dermaroller™ procedure can cause areas of bruising although this would not normally be expected to occur, the eye contour being most at risk. Any bruising will be temporary.
There is a small risk that hyper-pigmentation of the skin can occur after the procedure, although this is not normally expected as the epidermis of the skin is not removed as a result of the procedure. Failure to follow the sun expose and sun protection advice detailed below can increase this risk.

Please ensure you understand the potential complications and personal requirements of the Dermaroller™ procedure over the page and please acknowledge the points and questions over the page.

Initials: _____ Date: _____

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	YES	NO
Are you allergic to local anaesthetics, do you have a history of anaphylactic shock (severe allergic reactions)? Do you consent to the use of a local anaesthetic?	☐ ☐	☐ ☐
Do you suffer from known allergies?	☐	☐
Have you taken oral retinoids (Roaccutane) in the past 12 months?	☐	☐
Are you using topical retinoids / vitamin A products?	☐	☐
Are you taking aspirin or other anti-coagulant treatments?	☐	☐
Are you taking / receiving steroids, chemotherapy, radiotherapy?	☐	☐
Are you taking any medication * (If yes, please specify below)	☐	☐
Will you refrain from intensive sun light exposure and/or from artificial UV exposure for a period of at least 2 weeks? Will you use a topical sun protection product with an SPF 50 or higher and with stated UVA protection on a daily basis with regular applications for the same period?	☐ ☐	☐ ☐
Do you suffer from any illness e.g. diabetes, angina, epilepsy, hepatitis, autoimmune disease?	☐	☐
Do you suffer from keloid or hypertrophic scars?	☐	☐
Do you have or have a history of herpes simplex (cold sores) or other skin infections?	☐	☐
Are you pregnant or is there any possibility that you are pregnant?	☐	☐
Are you breast feeding?	☐	☐
Do you have or have you had any form of skin cancer?	☐	☐
Have you undergone a laser resurfacing or skin peel in the last 6 weeks?	☐	☐

* Additional comments:

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I confirm that to the best of my knowledge that the information that I have supplied is correct and that there is no other medical information I need to disclose.

Patient's Signature (Please also initial and date page 1)	**Practitioner's Signature**
Date:	**Date:**