Dr. R. van Aardt
Cosmetic Medicine

# MICRO-NEEDLING / DERMA-ROLLING TREATMENT CONSENT

Name: ____________________________________________ Date of Birth: ____________________
Contact Tel # (Cell): _____-_____-________ (W): _____-_____-________ (H): _____-_____-________
Email: ____________________________________________ Consent to use: __Y __N
Address:

**Please Initial and Sign below**:

____ I hereby authorize Truro Medi Spa or any delegated associates to perform Micro-Needling/ Derma-Rolling procedure on me to treat ____________________.

____ I understand that this procedure treats skin texture, fine lines, wrinkles, scarring and stretch marks.

____ I understand that I may not experience complete clearance and that it may take multiple treatments. Some conditions may not respond at all and in rare cases may become worse.

I am aware of the following possible experiences/risks:

____ DISCOMFORT – Some discomfort may be experienced during treatment

____ REDNESS/SWELLING/BRUISING – Short term erythema (redness) or edema (swelling) of the treated area is common and may occur. There may also be some bruising.

____ PIGMENT CHANGES (skin color) – During the healing process, there is possibility that the treated area can become either hypo-pigmented (lighter) or hyper-pigmented (darker) compared to the surrounding skin. This is usually temporary but on rare occasion it may be permanent.

____ WOUNDS – Treatment can result in bleeding and/or scabbing of the treated areas. As this Medi-Spa is physician supervised if any of these occur please call the clinic..

____ INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop (pain, heat or surrounding redness), please call our office.

____ SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring it is IMPORTANT that you follow all post-treatment instructions carefully.

Micro-Needling/Derma-Rolling is contra-indicated in patients who have any of the following:

- Active cold sores
- Skin with open wounds
- Sunburn
- Excessively sensitive skin
- Dermatitis
- Inflammatory Rosacea
- History of significant allergies
- Rashes
- Accutane use within the last year
- Previous chemotherapy or radiation therapy
- Keloid scarring

By signing below I acknowledge and certify that I have read and fully understand the contents of the consent form for Micro-Needling/Derma-Rolling treatment and that the disclosures referred to herein were made to me.

| ______________________________ | ______________________________ | ____________________ |
|---|---|---|
| Print Name of Client | Signature of Client | Date |
| ______________________________ | ______________________________ | ____________________ |
| Print Name of Service Provider | Signature of Service Provider | Date |