Dr. R. van Aardt
Cosmetic Medicine

PLATELET-RICH PLASMA THERAPY
PATIENT CONSENT & INFORMATION

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

Please initial and sign below:

____ I understand the Platelet-Rich Plasma (**PRP**) Therapy information and Treatment Instructions and have had an opportunity to ask questions about the treatment.

____ I consent and authorize the Clinical Service Providers at this Medi-Spa to administer **PRP** treatment on me.

I understand:

____ There is an increased risks of side effects if I do not follow pre- and post-care instructions. The most common side effects are discomfort, pinpoint bleeding and minor bruising. There may be risks not yet known at this time.

____ Most issues require multiple PRP sessions approximately one month apart. Results may wear off if not maintained. Results vary between individuals. Some people exceed our expectations and some people respond below expectations. Although good results are expected, with the focus on improvement and not perfection, every person is unique and it is impossible to guarantee results.

____ A minimum of three treatments one month to six weeks apart is recommended for optimal results. Maintenance treatment is recommended every 9-12 months.

The risk of side effects or decreased/lack of response to treatment may increase with certain medical conditions such as:

Please pick all that apply to you:

__ HIV __ Lupus __ Rheumatoid Arthritis __ Colitis
__ Diabetes __ Smoking __ Prednisone Medication __ Blood Disorders
__ Anaphylaxis __ Ibuprofen __ Non-steroidal anti-inflammatory

Increase risk of bleeding if any of the following medications are used:

__ Aspirin __ Coumadin __ Plavix __ Vitamin E / Certain Herbal Products

__ Pregnant or trying to get pregnant __ Breastfeeding

____ I acknowledge that __some or __none of the above conditions apply to me and if they do I am aware of the increased risks as explained to me during my consult.

____ I am aware that there may be other options for treatment including not having this procedure and have explained to me and I have had time to ask questions regarding these.

____ I acknowledge that pre- and post photographs will be taken and that these may be used for educational or promotional material as per my consent.

____ I have received a PRP Procedure Instructions & Tips and Post Treatment Instruction Form.

By signing below I have read and understand this **PRP** consent form. I have been given sufficient time to ask questions these have been answered satisfactorily. I accept the risks and complications of the procedure.

_____	_____	_____
Print Name of Client	Signature of Client	Date
_____	_____	_____
Print Name of Service Provider	Signature of Service Provider	Date