# GD™ Skin Rejuvenation
# Example Patient / Client Consent Form

| **Patient / Client Details** | |
|---|---|
| Name | |
| Address | |
| | |
| | |
| | |
| Post Code | |
| Telephone | |
| DOB & Sex | |

I am voluntarily consenting to a GD™ Skin Rejuvenation 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 a Dermaroller™ medical device that creates controlled micro-medical needle punctures of the skin surface. I also understand that I may require a series of GD™ Skin Rejuvenation treatments, normally with at least 6 weeks between procedures, to achieve the maximum cosmetic result. I understand I will require topical skin anaesthesia before the procedure and I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me regarding the outcome of the procedure.

I have had the following explained to me and have had the opportunity to discuss the procedure and its benefits and risks:

- That immediately after the GD™ Skin Rejuvenation procedure the skin will be red, resembling moderate sunburn, and as the skin naturally heals the redness will resolve. The skin may remain red for three to four days after the GD™ Skin Rejuvenation 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 is used for cleansing. If you are taking any medication or dietary supplements that can affect platelet function and bleeding time (see Ques. 8 overleaf) the period of redness can be extended.
- The GD™ Skin Rejuvenation procedure can cause areas of bruising although this would not normally be expected to occur, the eye contour being the area at most risk. If you are taking any medication or dietary supplements that can affect platelet function and bleeding time (see Ques. 8 overleaf) the severity and period of bruising can be extended, also the presence of petechiae (small red or purple spots beneath the skin) may be observed.
- There is a small risk of infection of the treated skin area after the GD™ Skin Rejuvenation procedure although this is not expected to occur due to the sterility of the Dermaroller™ medical device and the minimally invasive nature of the micro-medical needles.
- There is a small risk that hyper-pigmentation of the skin can occur after the procedure, although this is not normally expected. Failure to follow the sun exposure and sun protection advice detailed below can increase this risk.

Please answer the points and questions below. A yes answer to any of the questions will require further discussions and may require further consent from you to enable the procedure to take place.

# GD™ Skin Rejuvenation
# Example Patient / Client Consent Form

| | | YES | NO |
|---|---|---|---|
| 1 | Do you have or have a history of herpes simplex (cold sores) or other skin infections? | ☐ | ☐ |
| 2 | Do you have active acne with papules or pustules? | ☐ | ☐ |
| 3 | Do you have or have you had any form of skin cancer? | ☐ | ☐ |
| 4 | Do you suffer from keloid scars? | ☐ | ☐ |
| 5 | Are you allergic to local anaesthetics, do you have a history of anaphylactic shock (severe allergic reactions)? | ☐ | ☐ |
| 6 | Do you consent to the use of a local anaesthetic? | ☐ | ☐ |
| 7 | Do you suffer from any other known allergies? | ☐ | ☐ |
| 8 | Are you taking Aspirin, Warfarin, other anti-coagulant treatments or any other medication or dietary supplements such as Omega-3 that can affect platelet function and bleeding time? | ☐ | ☐ |
| 9 | Are you taking any other medication (if yes, please specify below)? | ☐ | ☐ |
| 10 | Do you suffer from any illnesses e.g. diabetes, angina, epilepsy, hepatitis, auto immune disease? | ☐ | ☐ |
| 11 | Are you taking / receiving steroids, chemotherapy, radiotherapy? | ☐ | ☐ |
| 12 | Are you using topical retinoids / vitamin A products? | ☐ | ☐ |
| 13 | Have you taken oral retinoids (Roaccutane) in the past 12 months? | ☐ | ☐ |
| 14 | Have you undergone a laser resurfacing or skin peel in the last 6 weeks? | ☐ | ☐ |
| 15 | Are you pregnant or is there any possibility that you are pregnant? | ☐ | ☐ |
| 16 | Are you breast feeding? | ☐ | ☐ |
| 17 | Will you refrain from intensive sun light exposure and/or from artificial UV exposure for a period of at least 2 weeks? | ☐ | ☐ |
| 18 | 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? | ☐ | ☐ |

Additional comments:

_____
_____
_____
_____
_____
_____
_____

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.

| Patients Signature (Please also initial & date page 1) | Practitioners Signature |
|---|---|
| | |
| Date: | Date: |
| Clinic Name: | Practitioner Name: |
| Clinic Address: | |