Treatment Form – Vitamin Injections

Title (Mr, Mrs, Miss, Ms.): .....

First Name: ..... Surname.....

Address:.....

.....

Post Code: ..... Date of Birth.....

Tel: ..... Mobile: .....

E-Mail: .....

_____I am voluntarily consenting to the Vitamin Injection.

_____I understand that the procedure is a nutritional supplement and not a replacement for medical treatment or diagnosis.

_____I also understand that I may require a series of treatments over_____ week(s)/month(s). Then 1 injection every _____ week(s)/month(s).

_____ I have been informed that treatment can take 1-4 weeks to notice results and a load up dose may be necessary for best results.

_____I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure.

_____ If symptoms persist or become worse, I agree to seek medical advice as symptoms may be related to other diseases.

_____I understand that the treatment can cause mild to moderate stinging sensation in the treated area that can last up to four hours.

____ I need to avoid hot baths and showers, saunas, steam rooms and public pools for 48 hours post treatment.

____There is a small risk of infection of the treated skin area after the procedure, although this is not expected to occur due to the sterility of the medical devices used.

____ Other side effects include, bruising, swelling, hematomas and slight reddening of the area that may be present for up to 7 days.

____ I understand that stopping treatment at any time may cause the original symptoms to return.

____ I understand that individual results may vary, and no guarantees are made in regard to the expected outcomes of this procedure. I am happy to proceed with this treatment on this basis.

____ I confirm that the treatment and product being used has been explained to me in full and that I am happy to proceed with the treatment on that basis. I have asked all questions that I may have and received all appropriate aftercare.

____ I understand that I am undertaking this treatment knowing the full facts, side effects, treatment outcomes and complications and I will not hold the clinic responsible should any issues mentioned above occur.

____ I give full consent to the use of my before and after images for marketing purposes, providing all identifying features are covered and that there is no way to identify myself from the image. Images will be kept for 6 years and may be used in the event of a claim being brought against us. They will be stored on a password encrypted hard drive.

____ Under GDPR rule I understand that I have full access to all data held on me. This data will be held by the clinic for no longer than 6 years for insurance purposes, after which, digital information will be deleted permanently, and paper documents will be destroyed. All information on myself is kept on password encrypted hard drives or locked in filing cabinets to which only selective staff members have access. None of my personal data will be sold or used for anything other than to provide the services of this clinic.

Please ensure you understand the potential complications and personal requirements of the procedure indicated below and please acknowledge or answer the points and questions:

	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 any known allergies? If yes, please specify on the next page of this form.		
Have you taken oral retinoids (Roaccutane) in the last 12 months?		
Are you using topical retinoids/Vitamin A products?		
Do you have active acne with papules or pustules?		
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?		
Do you have or have you had any form of skin cancer?		
Are you taking/receiving steroids, chemotherapy or radiotherapy?		
Are you taking any other medication? If Yes, please specify on the next page of this form.		
Do you suffer from any illness e.g. diabetes, angina, epilepsy, hepatitis, auto immune disease?		
Do you suffer from keloid or hypertrophic scars?		
Do you have a history of herpes simples (cold sores) or other skin infections?		
Have you undergone a laser resurfacing or skin peel in the last 6 weeks?		
Are you pregnant or is there any possibility that you are pregnant?		
Are you pregnant or breastfeeding?		
Will you refrain from intensive sunlight exposure and/or artificial UV exposure for a period of at least 2 weeks?		
Will you use topical sun protection products with an SPF 30+ or higher and with stated UVA/UVB 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.

I understand that treatments and products is not an exact science and therefore that no guarantee can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is an improvement, not perfection and that there is no guarantee that the anticipated results will be achieved.

Patient/Client Signature: ..... Date: .....

Practitioner Signature: ..... Date: .....

Treatment No.	Date.	Needle Batch No.	Product Batch No.
Notes:		Injection Site:	
		Next Visit Date:	
		Administered by:	
I _____ (Client Name) have checked that there are no changes to my medical history since my last appointment.		Clients Signature:	

Treatment No.	Date.	Needle Batch No.	Product Batch No.
Notes:		Injection Site:	
		Next Visit Date:	
		Administered by:	
I _____ (Client Name) have checked that there are no changes to my medical history since my last appointment.		Clients Signature:	

Treatment No.	Date.	Needle Batch No.	Product Batch No.
Notes:		Injection Site:	
		Next Visit Date:	
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I _____ (Client Name) have checked that there are no changes to my medical history since my last appointment.		Clients Signature:	