Derma Fillers Questionnaire Consent Form and Record Declaration

by the Aesthetic Therapist providing treatment

Declaration by the Therapist providing treatment

I am appropriately trained, insured and have suitable experience to provide this treatment. I have explained the intended benefits of the treatment to the client along with its limitations and any possible risk. I have discussed treatment alternatives, including not having the treatment. I have afforded ample opportunity to read and understand the written information provided, which also includes post-treatment advice.

I have discussed with the client in detail about what the procedure involves, and explained that the client may withdraw consent to treatment at any time.

Name:

Signature

Date:

Declaration by the client receiving treatment

I have received sufficient information about the aesthetic treatment I am to receive and read the information sheet about this procedure. I have detailed explanation of the procedure I am to undergo.
I fully understand the aims and objectives of the treatment. I am aware of the limitations, possible risks and unexpected side effects that may not be possibly anticipated beforehand; as well as the intended benefit to my appearance and wellbeing. I also understand the usual possible range of variation in the expected outcome of the treatment, which has been explained to me by the practitioner performing the treatment- procedure.
I understand that the local anaesthetic may be applied or injected.
I have had further opportunity to consult a medically qualified professional and have all my questions answered to my entire satisfaction.
Having considered all aspects, I have decided to have this treatment of my own accord with sole intention the anticipated benefit from the same, provided by the practitioner performing the treatment procedure. I understand that I will not be able to sue my therapist in case of any complications or be entitled to a refund if I am not happy with my procedure.
I agree to follow the post treatment advice provided. I hereby consent to receive the treatment described herein.
I further consent to be photographed before, during and after treatment. I understand that these photographs would remain the property of the professional practice and will not be used for marketing purposes without my explicit permission.
I understand my right to withdraw consent at any time.

Name:

Signature

Date:

122, Meanwood Road, LEEDS, LS7 2AS
t: 07553 465166 | e: info@lips6.co.uk | w: lips6.co.uk

Derma Fillers Questionnaire Consent Form and Record

Client Ref No.	
Aesthetic Therapist	

Name:	
D.O.B:	
Gender:	

email:	
Tel:	
Mobile:	

Address:	
Postcode:	

Reason for having treatment:	

HEALTH QUESTIONNAIRE **PLEASE CHECK BOX THE APPROPRIATE ANSWER**

A	Are you pregnant/breastfeeding	YES		NO	
B	Have you undergone any medical procedure in the past 4 weeks?	YES		NO	
	Have you undergone any surgical procedure in the past 6 weeks?	YES		NO	
C	Do you bruise easily?	YES		NO	
	Do you suffer from needle phobia?	YES		NO	
	Do you have history/have tendency to faint?	YES		NO	
	Do you have tendency to Keloid/excessive scarring?	YES		NO	
D	Have you ever tested positive for HIV or Hepatitis B/C?	YES		NO	
	Have you ever been diagnosed with any of the following? Angina/Diabetes/Epilepsy/Hepatitis A, Rheumatoid Arthritis	YES		NO	
	Have you ever been diagnosed with Multiple Sclerosis (MS), Myasthenia Gravis, or any other Neuromuscular Degenerative Disorder?	YES		NO	
	Have you ever been diagnosed with any severe mental condition? Requiring medication and/or hospital admission.	YES		NO	
E	Have you had an abnormal reaction to such a procedure before?	YES		NO	
	Do you have a tendency to develop cold sores, or had one in the past 2 weeks?	YES		NO	
	Do you have history of anaphylaxis (severe allergic reaction)?	YES		NO	
	Do you have history of allergy to any medicines/food or drink?	YES		NO	
	Have you ever had abnormal reaction to local anaesthetic (injection/cream)?	YES		NO	
	Are you taking HRT, Steroids or blood thinners (anticoagulants, e.g. Warfarin)?	YES		NO	
	Have you taken any Antibiotics in the past week? Especially Gentamicin, Amikacin, Neomycin, Netilmycin, (Netromycin) or Tobramycin in the area to be treated?	YES		NO	
	Have you received any aesthetic treatment (e.g. fillers) in the past 2 weeks?	YES		NO	
	Do you suffer from active skin condition: Eczema, Acne, Psoriasis or Cancer?	YES		NO	
	Do you have any permanent implants?	YES		NO	

If you answered **YES** to any of the above questions, please provide further information
If you are contra indicated, you may be referred to your GP, your treatment may be referred or refused

Name:

Signature

Date: **Age:**

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