

PREPARATION & CONSENT FOR MEDIK8 TITANIUM DERMAROLLER

PATIENTS WHO SHOULD NOT BE TREATED:

- Active cold sores or warts,
- Skin with open wounds,
- Sunburn,
- Excessively sensitive skin,
- Dermatitis
- Inflammatory rosacea in the area to be treated.
- Inform the esthetician if you have any history of herpes simplex.
- History of allergies,
- Rashes,
- Other skin reactions,
- Sensitive to any of the components of this treatment.
- If you have taken Roaccutane within the past year,
- Treated with chemotherapy or radiation therapy.
- Keloid Scaring

ONE-WEEK BEFORE YOUR MEDIK8 TITANIUM DERMAROLLER TREATMENT

Avoid these treatments for one entire week prior to your Dermaroller treatment:

- Electrolysis
- Waxing
- Depilatory Creams
- Laser Hair Removal

TWENTY-FOUR HOURS BEFORE YOUR TITANIUM DERMAROLLER TREATMENT Stop using:

- AHA or BHA, or benzyl peroxide
- Any exfoliating products that may be drying or irritating

THE DAY OF YOUR DERMAROLLER

Cleanse your skin in the morning and do not apply makeup on face other than eyes and lips.

AFTER YOUR DERMAROLLER TREATMENT – it is imperative that the health of your skin and the success of your treatment that these guidelines be followed:

1. Do not use any AHA's or BHA on your skin for 24hours
2. It is imperative that you use a sunscreen with an SPF of at least 30 and avoid direct sunlight for at least 1 month.
3. Patients with hypersensitivity to the sun should take extra precautions to guard against exposure immediately following the procedure, as they may be more sensitive following the peel.
4. Your skin may be more red than usual for 2 hours.
5. Please avoid strenuous exercise during this time.
6. You may have some peeling or flaky skin for a few. days
7. DO NOT PICK OR PULL THE SKIN.
8. When washing your face, do not scrub. Use a gentle cleanser designed for Sensitive skins
9. Apply a light moisturiser as often as needed to relieve dryness and tightness.
10. Do not have any other facial treatment for at least one week after your Dermaroller treatment

Although the Dermaroller treatment is effective in most cases, no guarantee can be made that a specific patient will benefit from the treatment.

- The Dermaroller is recommended for Photodamaged skin; Rough texture; Aging skin; Photo-damaged skin and Hyperpigmentation

A consultation and skin evaluation by your skin care professional prior to your treatment is important.

Please read and sign the following:

PLEASE CONFIRM THAT YOU HAVE NONE OF THE FOLLOW -BEFORE AGREEING TO GO AHEAD WITH THE PEEL

Pregnancy	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Use of Roaccutane	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Cold sores (Herpes outbreak)	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Acne	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Plastic surgery in last 6 months	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Use of Retin A/Retinova/Retinol products	<input type="checkbox"/> Yes		<input type="checkbox"/> No	

Further Considerations for Consent

- 1) I acknowledge that no guarantee has been given to me as the condition of the complexion, skin pore size, wrinkle reduction, or the amount or percentage of improvement expected following the treatment.
- 2) I acknowledge that for many conditions, more than one Dermaroller Treatment may be required in certain areas to achieve the desired result. In fact, a course of a minimum of 6 is recommended for best results.
- 3) I acknowledge that no guarantee or assurance has been made by anyone regarding the procedure that I herein request and authorize.
- 4) If I know or suspect that I may be pregnant, I will inform the operator prior to treatment.

Consent

By signing below, I acknowledge that I have read the foregoing informed consent regarding the Dermaroller treatment and I feel I have been adequately informed regarding the associated risks. I hereby give consent to the Dermaroller procedure to be performed by a Qualified Person

Treatment No 1 Date _____	

Patient Signature	Practitioners Signature

Treatment No 2 Date _____	

Patient Signature	Practitioners Signature

Treatment No 3 Date _____	

Patient Signature	Practitioners signature

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