YOUR PLASMA PEN SPECIALIST PROVIDER:

TECHNICIAN NAME: _____

YOUR PLASMA PEN CONSULTATION RECORD

Plasma Pen is a procedure that can only be performed by a specifically trained and qualified specialist therapist using approved equipment to shrink the skin using a sterile disposable probe. Your specialist technician is trained, qualified by Plasma Pen, has certification and is fully insured.

Before carrying out the treatment, you are as a patient are required to complete and sign all relevant areas of this consultation record thus giving your absolute consent to treatment. Additionally, you will need to disclose your full medical history as that will determine whether you are a suitable candidate for the proposed treatment. If the specialist does not think you are suitable for the treatment then your treatment cannot and will not be carried out.

Your specialist will discuss your procedure with you, in full, including what it will involve and the likely benefits. Realistic expectations will be agreed and they will explain any risks, the healing process and will then advise you upon any further treatment you may require if/where necessary. You will then be provided with written aftercare information for you to keep and refer to during the subsequent healing process and it is essential you follow these instructions. Any contra-indications will be recorded on this consultation form and will be used as a reference for any future visits.

It is important that you clearly mark any areas of this form that you wish to have clarified or discussed further. It is ultimately **YOUR** responsibility to ensure that you understand, in full, the Plasma Pen procedure and the expected outcomes **BEFORE** your treatment commences.

PLEASE READ ALL OF THE FOLLOWING CAREFULLY AND SIGN, WHERE INDICATED, when you are happy to proceed. You must ensure that all the points below have been discussed with your specialist technician. You are signing to state you understand and accept the terms of your treatment.

TERMS OF YOUR TREATMENT:

- You have chosen a cosmetic procedure that is not medically necessary
- “Fibroblasting” with Plasma Pen is an artistic process - not an exact science - and it cannot guarantee an exact shrinkage result due to individual skin elasticity and the individual healing process
- Some results can be cumulative for optimal effects to be achieved and you may thus be required to return for additional treatments before your overall procedure is deemed complete. The payment for any additional work, if applicable, will be agreed with you prior to your treatment commencing
- Depending upon the area of your treatment, additional treatments cannot usually be preformed until 12 weeks after the date of your initial treatment. This is in order to allow the area treated initially to fully heal and for the full benefit of Plasma Pen to be apparent

- Your specialist will use a treatment plan to record the areas that you have chosen, the anaesthetic used, the probe used as well as pre and post treatment photographs. This information will be held securely in your consultation record. Without these photographs and these signed documents/forms then your technician will not be insured
- The skin type of every client is different and the healing process may in rare cases lead to some discolouration of the skin. Microdermabrasion, skin rejuvenation or other relevant treatment may thus be advised after the healing process is complete should this be the case
- After each treatment some swelling or redness may occur which is completely normal. In some rare cases there may be extreme swelling. Your specialist will give you appropriate advice and aftercare technique to help reduce this risk
- During your treatment you may experience some discomfort depending on the area being treatment. Your specialist will reassure you throughout and endeavour to make you feel comfortable
- Since the treatment includes small burns to the skin, you may experience the smell of charring during your treatment. This is perfectly normal
- You **must** adhere to the specialist's aftercare advice given to you following your treatment. This is very important as it will reduce the risk of post-procedural infection upon leaving the clinic. You must let the treated area heal properly. Avoid picking, plucking or knocking as this will hinder the healing process and could make the treatment appear uneven thus requiring further work. Your aftercare regime can make a huge difference to your ultimate results
- Please be aware that any subsequent skin altering procedures such as plastic surgery, implants, injectables and weight gain may alter the Plasma Pen look

Sign: _____

YOU MUST COMPLETE THE FOLLOWING YOURSELF:

YOUR FULL NAME:	**YOUR DATE OF BIRTH (DD/MM/YY):**
ADDRESS: **POSTCODE:**	**TELEPHONE:** **MOBILE:** **EMAIL:**
YOUR OCCUPATION:	**PACKAGE:**
TREATMENT AREA(S):	**PRICE AGREED:**

Your specialist will follow guidelines as outlined in section 15 of the Local Government Act 1982. In addition to this, it is highly recommended by Plasma Pen that your trained specialist uses aseptic conditions throughout your treatment.

PHOTOGRAPHIC CONSENT:

I consent to photographs being taken **BEFORE, DURING and AFTER** my Plasma Pen procedure. I agree to these being stored with my case file and that they will only be used with my written consent for any additional promotional purposes.

Sign: _____

PATCH TEST/WAIVER: (Please circle A or B)

(A) I understand that a skin test can determine whether I will experience a reaction to the products used by the specialist within 48 hours of the treatment. However, I accept this will be inconclusive as to whether I will have an allergic reaction at any time in the future. I therefore waiver my option to an allergy test and thus wish to proceed with treatment

(B) I have undergone or been offered an allergy test prior to initial treatment. I release the specialist from liability related to any allergic reactions I may experience associated with either the application of pre-treatment cream or any other products used after the procedure, immediately or at a later date

(C) If relevant to my local authority, I can confirm that I have applied any numbing cream used for my treatment myself

Sign: _____

CONSENT:

I understand that my specialist technician will be in direct contact with me in relation to the Plasma Pen treatment. This treatment involves the use of a disposable probe. All other equipment is sterilized before use, all surfaces involved in the process are protected and gloves will be worn at all times by the specialist during the treatment. I hereby consent to receiving a Plasma Pen treatment. My specialist has explained the terms and conditions of the treatment and I have fully understood them. I hereby give written consent to the specialist, who is a fully trained and insured specialist, to carry out the treatment of my choice as requested by me on the consent and treatment agreement

Your Name:	**Technician Signature:**
Your Signature:	**Date:**

MEDICAL FORM: (To be completed by the client)

Full Name:
Date of Birth (DD/MM/YY):
Male or Female (please circle)
Have you received any skin tightening treatment before? YES / NO If **YES** please answer the following questions:
How long ago was your treatment?
What procedure(s) did you receive?
At what clinic did you receive the treatment?
Where you happy with the result? YES / NO **If no, please explain the reasons why.**
Are you over the age of 18?
Are you pregnant?

Are you under the influence of alcohol or drugs?
Are you in good health?

CLIENT SIGNATURE: _____

TECHNICIAN SIGNATURE: _____

MEDICAL CONDITIONS: (To be completed by the client)

Please answer **YES or NO** to the following questions. These details will then be discussed (in confidence) with your specialist.	**YES**	**NO**
Do you feel fit and well enough to have the Plasma Pen procedure today?		
Do you have any allergies or have you experienced allergic reactions to medicine or products such as latex gloves, plasters etc.? If so, please list:		
Are you currently taking any medication? If so, please list:		
Do you have, or are you planning to have any injectables, fillers or chemical peels in the near future?		
Do you have any imminent holiday plans?		
Do you suffer from epilepsy?		
Do you knowingly suffer from any infectious diseases?		
Do you suffer from high or low blood pressure?		
Do you suffer from diabetes?		
Do you have any respiratory problems?		
Do you suffer from, or have any problems with scars healing?		
Do you suffer from dizziness, or fainting attacks?		

Do you suffer from HIV/AIDS?		
Do you suffer from heart problems?		
Do you suffer from Hepatitis?		
Do you suffer with any Lymphatic problems?		
Do you suffer from Haemophilia?		
Do you suffer from skin problems? (i.e. Eczema, Psoriasis)?		
Do you have an allergy to penicillin?		
Do you suffer from Keloid scarring?		
Do you wear contact lenses?		
Do you suffer from Herpes Simplex (commonly referred to as cold sores)?		

If you suffer from any of the medical conditions listed then it is very important that you notify your specialist who can take the necessary precautions so as to ensure you receive the best Plasma Pen treatment and avoid any risks to your health or wellbeing

Notes to discuss:

I understand the importance of my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after the procedure. I understand that if there is any change in my medical history it is my responsibility to inform my specialist.

CLIENT SIGNATURE: _____

TECHNICIAN SIGNATURE: _____

PLASMA PEN TREATMENT PLAN:

This part of the consultation record is to be completed by your specialist in order to record important elements of your treatment. This form will be kept with your Medical and Consent forms. **THIS FORMMUST BE USED TO RECORD THE TREATMENT OF ONE AREA ONLY.** All other treatments must/will be recorded on separate treatment plan forms.

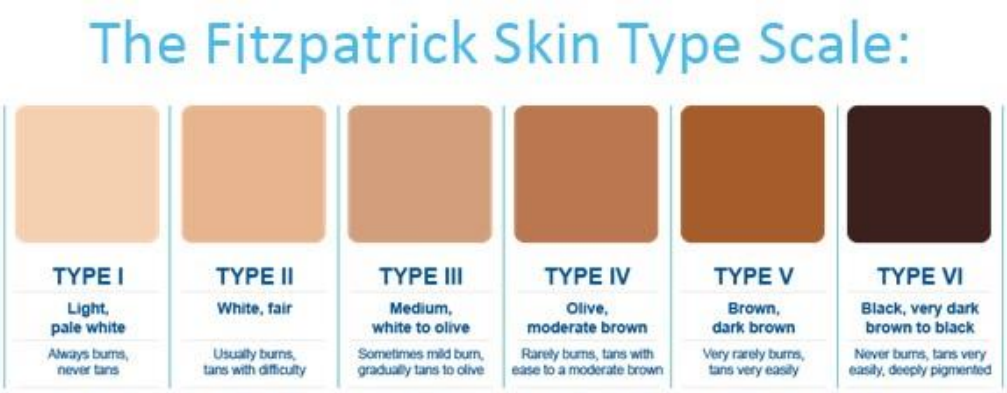
Treatment area(s) being completed:

Number of treatments recommended:

Treatment number: Please circle (only 4 treatments allowed per 1 area)

1st 2nd 3rd 4th

Indicate which scale: Please circle (Plasma Pen treatment is **not** allowed on Type IV, V or VI skin)



TYPE I TYPE II TYPE III TYPE IV TYPE V TYPE VI

Has the patient completed the Fitzpatrick Skin Type Questionnaire (Circle)? Yes No

For first visit only: Following consultation with your client, what is the agreed treatment and how many visits will it likely take to achieve?

What is the predicted outcome of treatment and your recommendations?

For 2nd and subsequent visits: Client must re-consent using the form area below

Were your client's expectations met?

Did the area heal as described?

What is the agreed objective for today's procedure?

What is the predicted outcome and recommendations?

Describe the treatment area including a description of the appearance of the skin:

CLIENT SIGNATURE: _____

TECHNICIAN SIGNATURE: _____

TREATMENT AGREEMENT

I, the specialist Plasma Pen technician, confirm that I have checked all the paperwork including consent forms and medical history. I have discussed all procedure points with my client and they understand all elements of the Plasma Pen treatment. Aftercare advice has been presented to the client and fully understood by them.

TECHNICIAN SIGNATURE: _____

DATE: _____

Please ask your client to read, understand and sign the following prior to their treatment:

I, the client, agree with all points listed and discussed, and wish to proceed as recorded. I participated fully in the decision for selected area or areas intended for my Plasma Pen treatment. I hereby agree to follow aftercare advice.

CLIENT SIGNATURE: _____

DATE: _____

RECORDED DOCUMENTATION:

Treatment area(s):	Any other treatments on this day:
Probe Used:	Lot / Expiry:
Anaesthetic Used:	Lot / Expiry:
Photographic Evidence:	Fitzpatrick scale:
Tolerance Level (1 Lowest 10 Highest):	Were any other people present?

NOTES: Please record any comments here that were made by the client and/or to the client after the procedure and information relating to further treatments required.

MY PLASMA PEN PROCEDURE: To be completed by the client at the end of the procedure

My procedure has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns with my specialist.

I fully understand my aftercare instructions and I have been provided with an aftercare advice sheet that I commit to follow for my own benefit.

CLIENT SIGNATURE: _____

TECHNICIAN SIGNATURE: _____