PATIENT INFORMED-CONSENT – PLATELET-RICH PLASMA (PRP)

INSTRUCTIONS

This is an informed consent document, which has been prepared to help your practitioner inform you about Platelet-Rich Plasma (PRP) treatments. Platelet-Rich Plasma (PRP) is a natural product derived from your own blood used to help tissue heal and help grow new cells. The PRP is applied topically, injected into skin or used in a combination thereof, depending on the type(s) of treatment desired.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for the procedure as proposed by your practitioner.

DESCRIPTION OF TREATMENT

This treatment involves the collection of your blood using a simple blood draw, (approximately 8-30mL), which is then put into a centrifuge and spun down to separate out the plasma and platelet portions using the separator gel in the PRP tube as a special filter. The platelet-rich plasma (PRP) portion of your blood is then drawn off and injected or topically applied back into your skin to help stimulate new collagen production, and to re-energize new cell turnover, or tissue healing. The product injected into you is 100% your own blood by-product. This process is referred to as an autologous procedure or treatment.

CONTRAINDICATIONS / MEDICAL HISTORY

You should not have PRP treatment done if you have any of the following conditions:

- Skin Conditions and Diseases, including: Facial cancer, past and present. This includes SCC, BCC and melanoma, systemic center, chemotherapy, steroid therapy, dermatological diseases affecting the face (ie: Porphyria, Lupus).
- Blood Disorders and Platelet Abnormalities
- Anticoagulation Therapy (i.e.: Warfarin, etc.)
- Acute and Chronic infections
- Severe metabolic and systemic disorders
- Chronic liver pathology
- Systemic use of corticosteroids within two weeks of procedure
- Pregnant or breastfeeding
- Systemic use of anti-inflammatory medications such as aspirin, naproxen, etc., or over-the-counter remedies such as St. John's Wort or garlic within two weeks of procedure

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray): Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum or nasal spray) are at a greater risk for complications of skin dying, delayed healing and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

_____I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

_____I am a smoker or use tobacco/ nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

It is important to refrain from smoking at least 2 weeks before your PRP procedure and until your physician states it is safe to return, if desired.

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ADDITIONAL MEDICAL INFORMATION:

Female Patient Information: It is important to inform your practitioner if you use birth control pills, estrogen replacement, or if you believe you may be pregnant. Many medications including antibiotics may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy.

Intimate Relations: Minimally invasive procedures involve coagulating of blood vessels and increased activity of any kind may open these vessels leading to a bleed, or hematoma. Increased activity that increased your pulse or heart rate may cause additional bruising, swelling and the need for surgery to control of bleeding. It is wise to refrain from sexual activity until your physician states it is safe.

Side Effects: While the risk of allergic reaction is very low, due to PRP being an autologous procedure, you will likely experience mild to moderate swelling of the treated area. This will last about 12-24 hours, and may be treated with ice or cold compresses to the affected area. Please follow practitioner's post-procedure instructions.

PATIENT CHECKLIST

Please review and check off each item below:

____ I hereby request and authorize the use of PRP and understand this procedure requires a simple blood draw.

____ The details of the procedure have been explained to me, and I have no further questions.

____ Alternative methods, their benefits and disadvantages have been explained to me.

____ I understand PRP involves a series of treatments to achieve optimum results and the costs have been explained.

____ I understand the effects of this treatment are gradual, as the healing process of platelets and growth factors stimulate a cell response that helps collagen regenerate over time.

____I understand that with any facial injections, it is unlikely, but possible that small blood vessels could be broken, resulting in temporary swelling, bruising, redness and soreness.

____ I have informed my practitioner if I have been previously injected with temporary or permanent cosmetic fillers.

____ I understand any injection carries a minimal but potential risk of infection.

____ I have informed my practitioner of all of my known allergies.

____ I have no muscle or nerve conditions.

____ I have not had chemotherapy or radiation treatments within the last 12 months.

____ I have not used Accutane (isotretinoin) in the past 12 months.

____ I am not currently pregnant or breastfeeding.

____ I have informed my practitioner of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and any other vitamins or supplements.

____ I have refrained from taking Vitamin E, Fish Oil or other supplements or medications that cause thinning of the blood, for the last 14 days.

____ I have been advised whether I should take any or all of the medications on the days surrounding the procedure.

____ I am aware and accept that no guarantees about the results of the procedure have been made or implied.

____ I understand and agree that photographs will be taken before and after each procedure(s).

Patient Initials _____

PRP CONSENT FOR PROCEDURE OR TREATMENT

1. I understand that due to the natural variation in quality of Platelet-Rich Plasma (PRP), results will vary between individuals. I understand that I might require additional treatments to achieve my desired outcome.

2. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that there is no guarantee as expressed or implied as to the success or outcome.

3. I have been informed that some of the side effects of PRP treatment may include: pain or itching at the injection site; bleeding, bruising or swelling; infection; short-term flushing of the skin; injury to a nerve and /or muscle; dizziness or fainting; temporary blood sugar increase; allergy

4. I consent to photographs for use in my medical record, medical education and advertising purposes. I understand that I will not be identified by name and that any and all identifying mark or features will be cropped, masked or erased.

5. I understand the risks and benefits of PRP therapy, and all of my questions have been answered.

_____

Patient or Person Authorized to Sign for Patient/Name

Date: _____

_____

Physician Signature