166 Pasadena Dr. Suite 100
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Lexington Plastic Surgery™

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MICRONEEDLING

REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT: _____ DATE: ____/____/____

The following has been explained to me in general terms and I understand that:

I hereby authorize Dr. Gerstle or any delegated associates to perform Microneedling Therapy (Collagen Induction Therapy). I understand that this procedure is purely elective.

What to Expect:

• Depending on the area of your face or body being treated and the type of device used (i.e. needle length), the procedure is well-tolerated and in some cases virtually painless, feeling only a mild prickling sensation.

• Your practitioner may offer ProNox or apply a topical anesthetic to your skin prior to treatment to

reduce any pain and discomfort.

• Your skin will be pink or red in appearance, much like a sunburn, for a couple of hours following treatment.

• Minor bleeding and bruising is possible depending on the length of the needle used and the number of times it is pressed across the treatment area.

• Your skin may feel warm, tight, and itchy for a short while. This should subside in 12-48 hours.

Possible Side-Effects:

• Side effects or risks are minimal with this type of treatment and typically include minor flaking or dryness of the skin with scab formation in rare cases.

• Milia (small white bumps) may form; these can be removed by the practitioner.

• Hyper-pigmentation (darkening of certain areas of the skin) can occur very rarely and usually resolves after a month.

• If you have a history of cold sores, this procedure may cause flare ups.

• Temporary redness and mild-sunburn effects may last up to 4 days.

• Freckles may temporarily lighten or permanently disappear in treated areas.

• Other potential risks include: crusting, itching, discomfort, bruising, infection, swelling, and failure to achieve the desired result. Permanent scarring (less than 1%) is extremely rare.

Initials _____

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I understand the following contraindications listed below and will notify my provider if any of the following apply to me:

• Active infections - viral, fungal, bacterial

• Rashes, warts, skin cancer

• Active acne

• Immune-suppressed patients

• Skin-related autoimmune disorders

• Pregnant or breast-feeding

• Patients on anticoagulants (NSAIDS, ASA, Coumadin/Warfarin)

• Recent ablative dermal procedures

• Rosacea

• Diabetes

• Actinic (solar) keratosis

• Keloids

The benefits and risks of the procedure have been explained to me, and I accept these and risks. The nature of my medical or cosmetic condition has been explained to my satisfaction as have been any substantial or significant risks of harm. I am also aware of and accept the risk of rare and unforeseen complications which may not have been discussed and which may result from this treatment.

I have had the opportunity to ask questions and seek clarification of this procedure and its alternatives including no treatment and my questions have been answered satisfactorily.

Signature of person giving consent: _____ Date: _____

Relationship to patient if not the patient: _____

Witness: _____ Date: _____

_____ Copy of consent form offered to patient

_____ Copy given _____ Declined