

## NB: CONSENT FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Web Address: \_\_\_\_\_

### **Disclosure and consent for permanent cosmetics and dermal procedures.**

I, \_\_\_\_\_ as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure. You have described the recommended procedure to be used as Micro Pigment Implantation, the process of implanting micro insertions of pigment into the dermal layer of skin. I voluntarily request as my permanent cosmetic technician, Emily Laubscher from Elegance on the move may deem necessary to perform on my body the following procedure(s):

\_\_\_\_\_

### **Please check one:**

\_\_\_\_\_ I hereby authorize Emily Laubscher to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of advertising.

\_\_\_\_\_ I hereby authorize Emily Laubscher to take photographs of the work performed both before and after treatment to be maintained only in file.

### **Please Initial what pertains to you:**

\_\_\_\_\_ I have been informed that I am in good health and not under the care of any physician.

\_\_\_\_\_ I am not under the care of a physician.

\_\_\_\_\_ I am currently under the care of a physician.

I am being treated for the following conditions: \_\_\_\_\_

\_\_\_\_\_

### **Disclosure and Consent for Permanent Cosmetics and Dermal Procedures**

\_\_\_\_\_ I hereby authorize the release of medical information to Emily Laubscher from Elegance on the move and have signed the attached release form.

\_\_\_\_\_ I understand that no 100% warranty or guarantee has been made to me as to the results of the procedure because the results are determined in part by the nature of the pathology of my skin type but not limited to the following

factors: A) Medication (Advise the specialist of any medication currently being administered), B) Skin characteristics: dryness, oiliness, sun-damage, thickness, color chemically-damaged and etc., C) My skin color blending with pigment colors, D) pH balance of my skin, which may change from visit to visit, E) Alcohol intake, smoking, etc., F) After care treatments G) Current state of health.

\_\_\_\_\_ I understand that a certain amount of discomfort is associated with this procedure. It has been explained to me that the following possibilities may occur upon completion of the procedure: Minor and temporary bleeding, bruising, redness, swelling; fever blisters on the lip area following lip procedures in individuals prone to them fading or loss of pigment. It has been explained to me that I must defer from donating blood for one year after the procedure

\_\_\_\_\_ I have been told that a follow up procedure may be required and that the colour of pigmentation may fade.

\_\_\_\_\_ I have been given an opportunity to ask questions about the procedures and the procedure to be used and the risks and hazards involved and believe that I have sufficient information to give this informed consent.

\_\_\_\_\_ I have agreed that should I have a complaint of any kind whatsoever, I shall immediately notify Emily

*Failure to follow post-treatment instructions may cause loss of pigment, discoloration or infection.*

*Remember, colours appear brighter and more sharply defined immediately following the procedure, As the healing progresses, colour will soften. Makeup may be used to tone colour down until this time.*

*If necessity, an appointment for a touch up procedure may be made between 4 weeks to 6 months following the initial procedure at no extra charge.*

**IF YOU HAVE ANY QUESTIONS CALL Emily Laubscher 072 781 2602**

### **Medical History Form**

Are you now or have you been under the care of a physician within the last two years? \_\_\_\_\_

If yes, Please provide reason, physician's name, address and phone number.

\_\_\_\_\_

### **Person to contact in an emergency:**

Name: \_\_\_\_\_

Address and phone: \_\_\_\_\_

List all medications, herbs, and vitamins you are currently taking, including Retin A, Glycolic Acid, and Acutane:

\_\_\_\_\_

Have you recently undergone a skin peel? \_\_\_\_\_

Have you been told to be pre-medicated to get your teeth cleaned? \_\_\_\_\_

If yes, why? \_\_\_\_\_

Have you ever had a cold sore or lesion on you lips or mouth? \_\_\_\_\_ If yes, Emily will not perform a lip procedure without client taking medication. Get a Rx. from you physician for Valtrex or Zivirex, and take 500 mg. 3 days before and 3 days after procedure. I \_\_\_\_\_, will take the medication above before any lip procedure.

Are you taking blood thinning anticoagulant medications? (Aspirin, Ibuprofen, Coumadin, or Alcohol)

\_\_\_\_\_

Are you pregnant or nursing? \_\_\_\_\_  
Do you wear contact lenses? \_\_\_\_\_  
Have you had laser eye surgery? \_\_\_\_\_

Please add any other illness or problems you have had in the past:  
\_\_\_\_\_  
\_\_\_\_\_

Whom may I thank for referring you? \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**Please circle any allergies you have:**

Latex	Novocain
Food	Lidocaine
Cosmetics	
Tetracaine	
Nickel	Epinephrine
Antibiotic ointment (bacitracin)	Benzocaine
Seasonal	Contrast dyes as used for x-rays

Other allergies \_\_\_\_\_

**Circle any conditions you have ever had**

Artificial Heart Valves/Vasc. Graft	Artificial joints
Abnormal heart conditions	AIDS/HIV positive
Anaphylaxis	Anemia/Hemophilia
Asthma	Atopic(allergy prone)
Blood disease	Herpes
Cancer	Prolonged Bleeding
Low Blood Pressure	Fainting Spells/Dizziness
Liver Disease	Glaucoma
Stomach Ulcers	Stroke
Tuberculosis	Tumors/Growths/Cysts Cancer
Chemotherapy/Radiation	Prosthetic Hip or Joint
Hepatitis	Fainting
Nervous Problems	Heart Murmur
Rheumatic Fever/Scarlet Fever	Psychiatric Care
Respiratory Disease	Shingles
Psoriasis	Skin Rash
High Blood Pressure	Circulatory Problems
Epilepsy	Diabetes
Thyroid Disturbances	Kidney Disease
Cold sores/Canker sores	Pacemaker/Heart Surgery