

**Client Consultation & Consent Form**
**Inkless Scar Revision (ISR) & Scar Camouflage**

**Client Information**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give consent for the treatment provider to call the contact in an emergency. Yes ☐ No ☐

**Medical Information**
Please answer the following questions truthfully. This information will help ensure your treatment is safe and effective.

1. Do you have any allergies (including to numbing agents (lidocaine/topical anaesthetic, latex, etc.)?
Yes ☐ No ☐
If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you currently taking any medications- blood thinning (including over the counter, vitamins, or supplements)?
Yes ☐ No ☐
If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you have any of the following conditions?
	* Skin conditions (e.g., eczema, psoriasis): Yes ☐ No ☐
	* Keloids or hypertrophic scars: Yes ☐ No ☐
	* Diabetes: Yes ☐ No ☐
	* Autoimmune disorders: Yes ☐ No ☐
	* Blood clotting issues/haemophilia: Yes ☐ No ☐
	* Aids: Yes ☐ No ☐
	* Hepatitis: Yes ☐ No ☐
	* Pregnancy or breastfeeding: Yes ☐ No ☐
	* Others (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you undergone any prior scar treatments (e.g., surgery, laser therapy)?
Yes ☐ No ☐
If yes, provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fitzpatrick Skin Type Classification**
Please indicate your skin type using the Fitzpatrick scale (select the option that best applies to you):

1. Type I: Pale white skin, always burns, never tans.
☐
2. Type II: White skin, burns easily, tans minimally.
☐
3. Type III: Light brown skin, burns moderately, tans gradually.
☐
4. Type IV: Moderate brown skin, rarely burns, tans well.
☐
5. Type V: Dark brown skin, very rarely burns, tans very easily.
☐
6. Type VI: Deeply pigmented dark brown to black skin, never burns.
☐

**Consent to Treatment**
Please read and acknowledge the following terms and conditions:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that I am over the age of 18 and not under the influence of alcohol or drugs. I desire to receive the following procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. **Treatment Process**: Inkless scar revision and scar camouflage are advanced cosmetic procedures that aim to improve the appearance of scars by stimulating collagen production or blending the scar with the surrounding skin tone.
2. **Risks and Side Effects**: Although the procedure is generally safe, potential side effects include redness, colour variation, pigment migration, fading, allergic reaction, swelling, infection, hyperpigmentation, or scarring. It is important to follow aftercare instructions to minimise these risks.
3. **Results**: I understand that results may vary depending on individual skin type, scar condition, and adherence to aftercare. Multiple treatments may be necessary to achieve optimal results.
4. **Aftercare**: After the procedure, specific aftercare instructions will be provided. It is my responsibility to follow these instructions to promote proper healing and assist with desired results.
5. **Contraindications**: The procedure may not be suitable for individuals with certain medical conditions (e.g., autoimmune disorders, active skin infections) or those who are pregnant or breastfeeding.
6. **Medical disclosures**: I will disclose any current medications I am currently taking, particularly those for depression or mood disorders.
7. **Photographic consent:** I understand that pre and post procedure photographs are required. These photos will be kept electorinially on file and will be secure and can be sent to me for my records. With my permission, the treatment provider may use anonymised portions of these photos for educational purposes and for portfolio development. If I do not consent to the photo use I will advise the treatment provider.
8. **Payment and Cancellation Policy**: Full payment is required after the treatment session. Cancellations or rescheduling must be done at least 24 hours in advance. Failure to do so may result in a cancellation fee/forfeit of $100 deposit.
9. **Privacy and Data Protection**: In accordance with New Zealand’s Privacy Act 2020, all personal information collected during the consultation and treatment process will be stored securely and used solely for treatment purposes.
10. **Legal Agreement**: I acknowledge that I have been informed about the procedure, risks, and aftercare requirements. I give my full consent to proceed with the treatment. I understand that the treatment provider cannot be held liable for any adverse effects that may arise from this procedure and that I agree not to bring any legal claims against the treatment provider in relation to this procedure. Finally, I also understand that this form constitutes a legally binding agreement.

By signing below, I acknowledge that I have read and understood the terms outlined above and give my consent to receive Inkless Scar Revision (ISR) or Scar Camouflage treatment. I confirm that I have initialled each paragraph, fully comprehend the explanations provided, and have had the opportunity to ask questions, all of which have been satisfactorily addressed.

I also understand that there is no 100% guarantee of pigment retention in areas requiring scar camouflage or corrective work. Individual results may vary due to factors beyond the provider's control. I take full responsibility for undergoing this treatment and acknowledge that procedure is non-refundable.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practitioner Notes** (for practitioner use only):

* Treatment Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Fitzpatrick Skin Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Aftercare Instructions Provided: Yes ☐ No ☐
* Follow-Up Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_