Illuminate Me

CLINICAL TREATMENT CONSULTATION & CONSENT FORM

FOR Dermapen

Dermapen™ Clinic: Illuminate Me		Date:
Dermapen™ Practitioner:		
PATIENT DETAILS		
Patient's full name:		Date of birth: Age:
Address:		
Phone: (M)	(H)	Email:
EMERGENCY CONTACT DETAILS		
Full Name:		Relationship:
Phone: (M)	(H)	Email:

- What are your primary skin concerns that you wish to be treated with Dermapen™?

- Do you have any important personal engagements in the next week? YES ☐ NO ☐

- Do you have any known allergies? (e.g. latex, metals, shellfish, nuts, penicillin, anaesthetic agents, p-aminobenzoic acid (paba), sulphonamide allergies)

- Are you currently experiencing any of the following active skin conditions? YES ☐ NO ☐

☐ Papulopustular rosacea	☐ Warts	☐ Open lesions
☐ Acne vulgaris stage III-IV	☐ Scleroderma	☐ Solar keratosis
☐ Herpes simplex	☐ Pemphigus/pemphigoid	☐ Skin cancer
☐ Dermatomyositis	☐ Bacterial/fungal Infections	

- Have you ever experienced any adverse reaction to any form of anaesthetic? YES ☐ NO ☐

If yes, please describe:

- Are you currently under medical supervision for any of the following? YES ☐ NO ☐

☐ Cardiac conditions/ arrhythmia	☐ Hepatic disease	☐ Human Immunodeficiency Virus (HIV)
☐ Auto-immune disorder	☐ Diabetes (type I or II)	☐ Pseudo cholinesterase deficiency
☐ Haemophilia	☐ Cancer	☐ Congenial or idiopathic methemoglobinemia

- Are you breastfeeding? YES ☐ NO ☐

- Are you currently taking (or withing the past 3 mths), any of the following medications or supplements? (please tick)

☐ Plastic/Cosmetic surgery	☐ Laser/IPL rejuvenation/hair removal
☐ Muscle relaxant/wrinkle reduction injections (including but not limited to Botox®or Dysport™ or Xeomin®)	☐ Radio Frequency (RF) skin tightening
☐ Dermal Fillers (including but not limited toJuve derm®, Restylane®, Belotero®, Captique® Esthelis®, Radiesse®, Aquamid®,Sculptra® or Artefill®)	☐ Hair removal (including but not limited to waxing, sugaring, plucking, threading or depilatory cream)
☐ Chemical peel (including but not limited to glycolic acid, lactic acid, mandelic acid or salicylic acid)	☐ Bacterial/fungal Infections
☐ Derma blading/derma planing	☐ Bacterial/fungal Infections

TREATMENT CONSIDERATIONS

You are scheduled for a series of non-invasive treatments with the BTL EMSELLA device.

BTL EMSELLA is intended to provide entirely non-invasive electromagnetic stimulation of pelvic floor musculature for the purpose of rehabilitation of weak pelvic muscles and restoration of neuromuscular control for the treatment of urinary incontinence in women.

Initials: _____

Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 6. The treatment is typically about 30 minutes per session, with sessions separated by at least 2 days, depending on your needs. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on the severity of your condition. The results will typically continue to improve over the next few weeks.

Initials: _____

There is typically no pain associated with your treatment and there is no anesthetic required. You will experience gradually increasing tingling feeling and muscle contractions. These sensations in the pelvic area are normal and expected. You remain fully clothed during the treatment.

Initials: _____

On the day of the treatment, you are advised to wear comfortable clothes which allow flexibility for correct positioning and increased comfort during the treatment.

Initials: _____

Please answer whether you currently have or have had any of the following:

pregnancy	YES	☐	NO	☐
cardiac pacemakers	YES	☐	NO	☐
implanted defibrillators, implanted neurostimulators	YES	☐	NO	☐
electronic implants	YES	☐	NO	☐
pulmonary insufficiency	YES	☐	NO	☐
metal implants	YES	☐	NO	☐
drug pumps	YES	☐	NO	☐
hemorrhagic conditions	YES	☐	NO	☐
anticoagulation therapy	YES	☐	NO	☐
heart disorders	YES	☐	NO	☐
malignant tumor	YES	☐	NO	☐
fever	YES	☐	NO	☐
allergy to any medications, food or other substances	YES	☐	NO	☐
taking prescription, herbal, or over the counter medication	YES	☐	NO	☐
any surgeries	YES	☐	NO	☐
any skin disease or sensitivity	YES	☐	NO	☐

If you answered YES to any of these questions, please specify:

For the full range of contraindications, warnings and cautions, consult your treatment provider.

I am aware that pregnancy is contraindicated and pregnant women can't undergo the treatment.

Initials: _____

I am aware that I can't undergo the treatment when menstruating.

Initials: _____

I understand there are certain risks associated with BTL EMSELLA treatments and they include but are not limited to: muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness. I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. Initials: _____

I am willing to fill in forms and/or anonymous questionnaires if requested, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. Initials:

I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. Initials:

I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects. Initials: _____

I have read the above information, and I request and give my consent to be treated with the BTL EMSELLA procedure by the physician(s) in the below stated practice and his/her designated staff.

Initials: _____

My signature below indicates that the above information is accurate and current.

Patient signature:_____ Date:_____

Witness (in print):_____Signature: _____Date:_____

Practice Name: Illuminate Me