The Day Spa
HyaPenPro™
The Professionals Choice

(920)-339-5250
info.dayspaescape@gmail.com
www.dayspaescape.com

Consultation & Consent Form

Fullname:

Mobile Number:

Address:

Email:

Date of Birth:

Zipcode:

General Questions:

	Yes	No
Are you pregnant or breast feeding?		
Have you a history of severe allergy/anaphylaxis?		
Are you currently on any medication, please list?		
Please give more details:		
Have you previously received any Aesthetic Treatments?		
Have you had any dermal fillers, absorbable dermal fillers, semi – permanent dermal fillers?		
Please List		
Have you been diagnosed with any auto – immune disease?		
Do you have any inflammatory skin conditions such as active acne and/or herpes (cold-sores)?		
Are you taking any steroids, blood thinners, aspirin, warfarin, apixaban, rivaroxaban?		
Do you suffer from any allergies, in particular allergies to hyaluronic acid or amide type anaesthetics or lidocaine?		
Do you suffer from untreated epilepsy?		
Have you ever had a raised scar?		
Have you been diagnosed with any cardiac conduction disorders? (Arrhythmia, atrial fibrivation/flutter, cardiac arrest, coronary heart disease and heart attack.		
Are you currently undergoing any dental treatment plan or have any loose teeth?		
Have you currently got any active infection or taking anti – viral medication, anti – fungal medication or antibiotics?		

This is a cosmetic procedure to enhance, volumise, repair or disguise signs of ageing. If you have answered yes to any of the above questions, you will not be able to proceed at this time.

If you have had filler in the last 12 weeks, you can only proceed if the brand you have had injected, is the same brand that is used in this procedure.

To the best of my knowledge, I have answered all the above questions correctly. I understand that this record will be retained and be properly disposed of if I cannot proceed to treatment.

Name:

Signature:

Date:

Photographic/Video Consent:

I hereby grant consent to photographs being taken BEFORE, DURING and AFTER my HyaPenPro procedure. I agree to these being stored with my case file.

Client Signature:

Patch Test/Waiver: For liquid products used (Tick A or B and sign to acknowledge C):

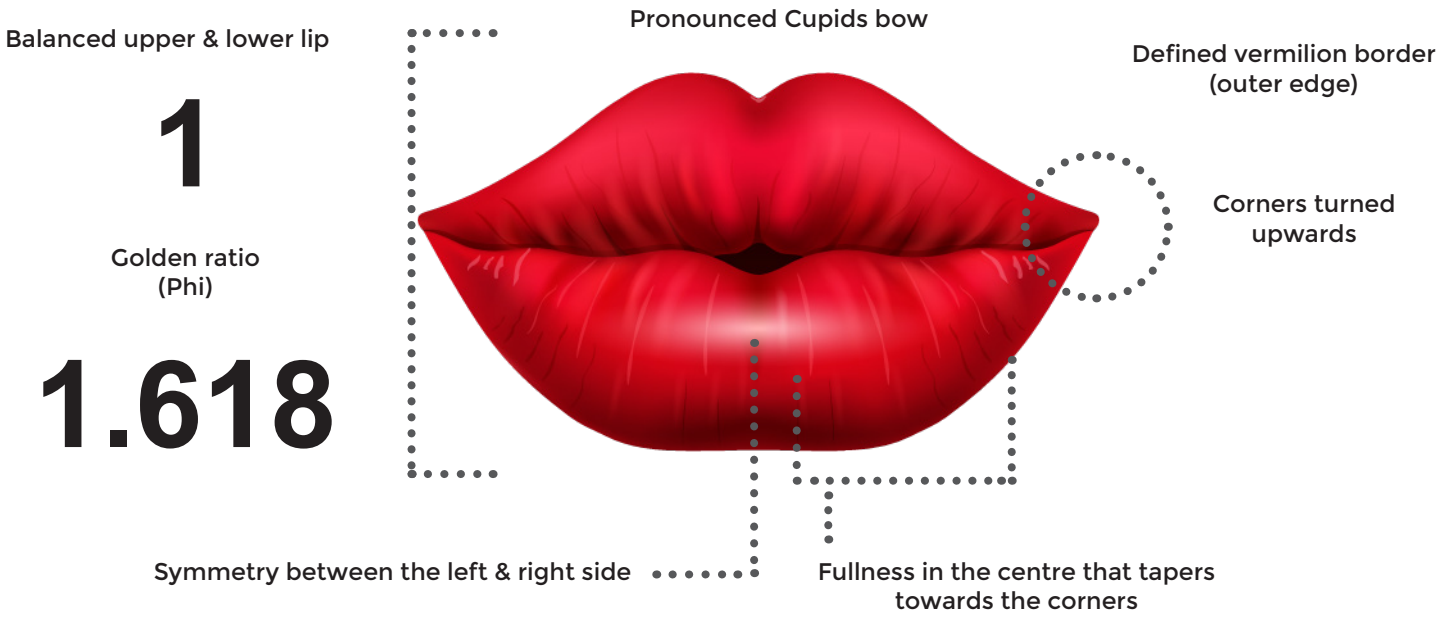
- [ ] I understand that a skin test can determine whether I will experience a reaction to the products used by the specialist within 48 hours of the treatment. However, I accept this will be inconclusive as to whether I will have an allergic reaction at any time in the future. I therefore waiver my option to an allergy test and thus wish to proceed with treatment.

- [ ] I have undergone or been offered an allergy test prior to initial treatment. In line with the relevant medical information and contraindications that will be discussed with my specialist, I release the specialist from liability related to any allergic reactions I may experience associated with either the application of any pre-treatment cream or any other products used before, during or after the procedure, either today or at a later date.
I have been advised that Teoxane & Revolax products both contain injectable Lidocaine which can lead to analaphatic shock.

- [ ] I have been advised that Hyafilia Classic (Hylauronuc Acid Filler) may lead to allergic reaction. I understand that an injectable allergy test cannot be carried out prior to this procedure.

Client Signature:

Treatment Plan Achieving Concordance:



Referring to photograph front profile and side profile imperfections/asymmetry and/or desired outcome:

1. Cupids Bow

2. Upper Lip

3. Lower Lip

4. Corners Of Lip

Proposed volume:	0.33mls/one cartridge	0.66mls/two cartridges	0.99mls/ three cartridges
ProposedCost	Cartridge 1 -	Cartridge 2 -	Cartridge 3 -
Actuation setting	0.01 ml (1 unit/ iu)	0.02 ml (2 unit/ iu)	
HyaPenPro Air Setting	1	2	3

Setting 1 - only on Cupids Bow/Thin/Dehydrated/History of Smoking/Aging/Fitzpatrick 1 Skin

Setting 2 - volume filling, back filling, from eight augmentation points.

Setting 3 - body only

Informed Consent for HyaPenPro:

I confirm that I have been informed that:

Hyafilia Classic (Hylauronuc Acid Filler) products are introduced into the Dermis to correct wrinkles/ of the face or skin or for lip augmentation. My Practitioner has explained the procedure to me and how the HylaPenPro sprays the product through the skin, without the use of needles.

I have been made aware that Hyafilia Classic (Hylauronuc Acid Filler) contain lidocaine, which may result in a positive anti – doping test and/or cause an allergic reaction and/or anaphylactic shock.

I have been made aware that The Hyafilia Classic (Hylauronuc Acid Filler) should not be used if I am taking drugs which inhibit hepatic function such as beta – blockers.

I understand listed side effects of lip augmentation are known as follows: Redness, Swelling, Stinging, Itching, discomfort, bruising, abscess, granulomas, haematomas, indurations, discolouration, hyper-sensitivity. The majority of these side effects are associated with injecting the product into the lip tissue, not known side effects, of using the HyaPenPro to volumise the lip.

I understand that the only product which can be used must be from the same range, if it is less than 12 weeks, since a previous treatment.

I understand that the aesthetic effects will last an average of three to six months but will vary depending on the condition of the skin, area treated, amount of product used and lifestyle factors such as sun exposure and smoking. I further understand that due to the high vascularisation and action of the lip area, that the average life of treatment in the lip area, is less than in other areas of the face.
I understand that any graphic, photograph or artwork used in HylaPenPro literature, is only representative of the treatment and my own treatment, is based on the plan originated today, with my agreement.

I understand that after treatment I should avoid smoking and sun exposure for 12 hours. I should also avoid extreme freezing and or heat treatments, such as a sauna, for 14 days.

My practitioner has provided me with enough information about the procedure to facilitate informed consent and has answered all remaining questions and I therefore consent to the described treatment.

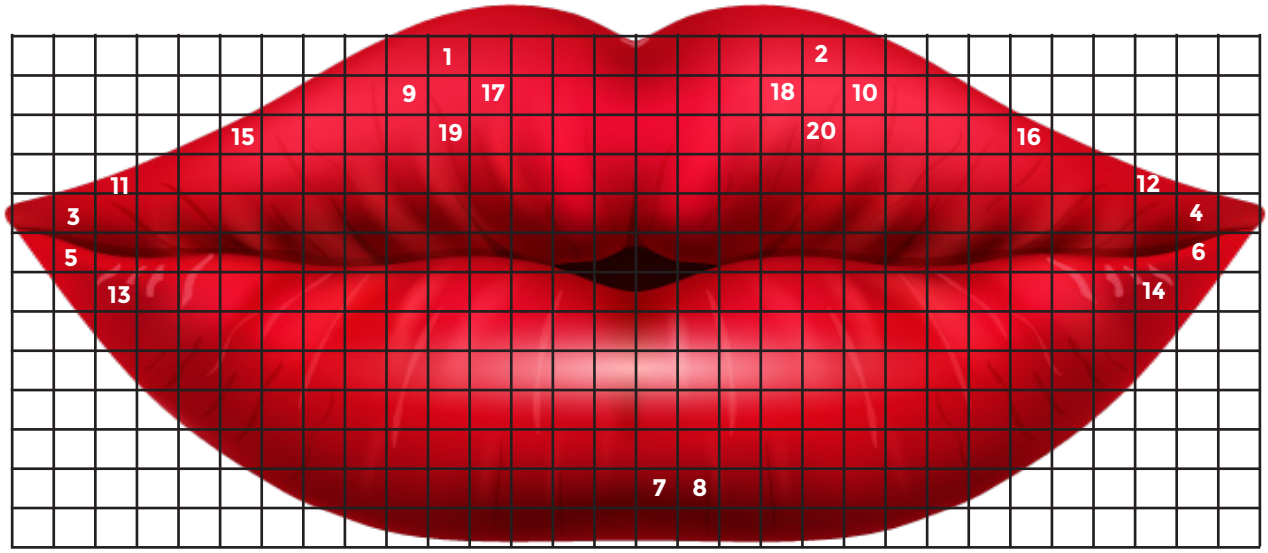
I have had enough time to consider and feel we have reached a therapeutic agreement based on the medical, aesthetic and outcome requirements listed as relevant for and or within the nature of the HyaPenPro treatment, with named product range.

Name:

Signature:

Date:

Treatment Record:



- [ ] Each square represents 1 actuation (spray) of the HyaPenPro
- [ ] Points 1-20 are for practitioner guidance to augment the platform & shape of the lip
- [ ] Please follow point guide to allow for any swelling in a given area to subside before next actuation
- [ ] Practitioner should then work systematically across upper and lower lip following agreed treatment plan

Product used:

Lot number/product sticker

Actual volume:

Bruising/bleeding/swelling (angio – Oedema)/redness (erythema) noted please provide details:

Post procedure photograph taken: ☐

I, the client can confirm that my procedure has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns about my treatment with my technician. I fully understand the aftercare instructions and I have been provided with an aftercare document which I commit to follow. Where relevant I have been provided with aftercare product. I have the contact details of my technician should I need to contact them.

Client Signature:

Date:

Technician Signature:

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