Microchanneling Sreening Form

BOLD RED items are hard contra-indication

Name: ______________________________ **Date:** ____________

Address: ____

City: ______________________________ **St:** ________ **ZIP:** ____________

Home Phone: ____________________ **Cell Phone:** ________________________

Email: ______________________________ **Referred by:** ____________________

Yes No Are you over 18 years of age?
Yes No Do you take aspirin or blood thinners regularly?
Yes No Have you had injectables in the past 30 days?
Yes No Have you taken any mood altering drugs in the past 8 hours?
Yes No Do you have a history of cold sores, herpes or fever blisters?
Yes No Are you sensitive to Latex?
Yes No Have you had a chemical or LASER peel? If so, when? ____________________
Yes No Do you have trouble healing?
Yes No **Are you currently undergoing radiation or chemotherapy?**
Yes No Are you currently using Retin-A, AHA, or other exfoliating skin care products?
Yes No Are you allergic to any metals?
Yes No Are you currently taking anti-inflammatory medications or steroids?
Yes No Are you allergic to any anesthetics, (any of the “caines”)?
Yes No Do you have a history of skin disease?
Yes No Do you have a history of skin sensitivity?
Yes No Are you currently taking vitamin A or E in any form?
Yes No **Are you pregnant or nursing?**
Yes No Are you currently being treated by a dermatologist?

Please circle any that apply to you:

Heart Condition	Hepatitis	HIV	Cold Sores
Hyper Pigment	Smoker	**Keloid Above Neck**	**Accutane in last 2 yrs**
Allergic to Steel	**Diabetes (uncontrolled)**	**Chronic Skin Disease**	**Hemophilia**

Practitioner’s Name: ______________________________

Practitioner’s Signature: ____________________________

procell THERAPIES

Microchanneling Consent Form

Patient name:_______________________________________**Date:** ______________

I authorize ____to perform Microchanneling on my skin, and to apply topical preparations as determined necessary.

I understand that Microchanneling is non-ablative skin rejuvenation & involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as reddening, peeling, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection & scarring.

These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time. I also have completed a medical history checklist and been informed about what I must do and “not do” before, during and after the procedure.

I consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I furthermore indemnify the authorized person herein, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.

Signature: ____Date: _______________

procell THERAPIES

Microchanneling Treatment Chart

Patient name:____

Date	Areas	Needle Depths	# Passes

Recommendations for Future Treatment:

____

☐ **Post care information given**

Notes:

____

____

Practitioner Sign Off:

Signed: _____________________________________Date: _______________

Signed: _____________________________________Date: _______________

Signed: _____________________________________Date: _______________

Signed: _____________________________________Date: _______________

Signed: _____________________________________Date: _______________

Signed: _____________________________________Date: _______________

Microchanneling Post-Care

1. If any Microchannel Delivery Solution roll-on remains, apply continually until gone.

2. No other products should be applied until the following day.

4. When the numbing wears off your skin may feel like a mild sunburn. You may apply cool compresses as desired.

5. Needle lengths of 0.25mm, 0.5mm will result in mild redness and swelling for up to 24 hours.

6. Needle lengths of 1mm, to 1.5mm will result in redness and swelling for up to 72 hours.

7. Beginning the following morning; apply the Livra Cellular Renewal Serum and Healing Accelerator to enhance results. (Cleanse and apply 1-3 pumps). Apply daily, morning and evening.

8. Peeling and skin sloughing may occur for several days after treatment.

8. Trans Epidermal Water Loss is a common temporary side effect and could leave you feeling dry. Keep the recommended moisturizer with you during the day and apply as frequently as necessary to avoid a dry sensation.

9. Return for a follow up treatment in about a month or as recommended

If prolonged irritation occurs, please **email or call** our office.

Practitioner Name: ____

Practitioner Phone #: ____

Practitioner Email: ____