Microchanneling Screening 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?

Specific for Scalp Treatments

Yes No Have you had Hair Transplants? If so, when? ____________
Yes No Do you have Psoriasis of the Scalp? If so, when? _________
Yes No Have you had Micropigmentation of the Scalp? If so, when? _______
Yes No Have you had any chemical services on the Scalp within the last 48 hours?

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: ____

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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 / hair rejuvenation and involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin / hair. 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 / scalp 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, type of hair loss 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 understand there will be NO refunds for any services I receive.

I understand Red light therapy will enhance and accelerate the procedure.

I consent to the use of Red light therapy.

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 have been made aware of the referral program my practitioner offers.

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: _________________

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Microchanneling Treatment Chart

Patient name:____

Date	Areas	Needle Depths	# Passes

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Recommendations for Future Treatment:

□ **Post care information given**

Notes:

____

____

Practitioner Sign Off:

Signed: ____Date: ______________

Signed: ____Date: ______________

Signed: ____Date: ______________

Signed: ____Date: ______________

Signed: ____Date: ______________

Signed: ____Date: ______________

Referrals:

Microchanneling Post-Care

1. If any Microchannel Delivery Solution roll-on remains, apply continually until gone. This is for skin and scalp treatments.

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

3. Scalp treatment nothing on the scalp for 90 min. e.g., Hats or Wigs

4. When the numbing wears off your skin may feel like a mild sunburn. You may apply cool compresses as desired. Scalp treatments no numbing is used.

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. This is available for purchase the day of your treatment. (Cleanse and apply 1-3 pumps). Apply daily, morning and evening.

8. Scalp treatments use Nioxin System and Supplement this is available to purchase the day of your treatment.

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

10. Scalp treatment air dry your hair DO NOT dry hair aggressively with a towel after washing.

11. Scalp treatment no chemical services on scalp area 48 hrs. prior to and after procedure.

12. 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.

13. Return for a follow up treatment 4 weeks for skin, 2 weeks for scalp or as recommended.

If prolonged irritation occurs, please **call**

Practitioner Name: Thereasa Dougan

Practitioner Phone #: 360-393-57891

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