EVOLUTION aesthetics

Micro Needling Treatment Information

Benefits

• Smoother skin
• Reduced pore sizes
• Brighter skin
• Smoother facial contours
• Reduction in facial lines
• Reduction in thread veins
• Reduction in pigmentation
• Reduction in scarring

Alternatives

• No treatment
• PRP
• Botox
• Dermal fillers
• Medical dermabrasion
• Sculptra
• Surgery

Reported Risks & Side Effects

Common Risks - 1 in 100 to 1 in 10
• Redness
• Swelling
• Bruising
• Pain
• Dry skin
• Peeling skin
• Unsatisfactory result

Uncommon Risks - 1 in 1,000 to 1 in 100
• Allergic reaction
• Infection
• Pigmentation risk

Aftercare

1. Avoid the sun for two weeks. Use a good sunscreen with a minimum SPF 30 during this time and continuously after the treatment for protection.

2. Wash your face with tepid water the evening of your treatment.

3. Use post procedure cream to soothe and moisturise the skin.

4. Do not take any inflammatory medicines for at least 2 weeks post treatment.

5. Avoid make-up for 12 hours.

Micro Needling Treatment Consent

I confirm that I have been informed that:

The procedure can result in an appearance enhancement and is typically used for skin rejuvenation and scar repair and that the treatment uses micro needling medical device that creates controlled micro-surgical needle punctures of the skin surface. I also understand that I may require a series of micro needling treatments, normally with at least 6 weeks between procedures, to achieve the maximum cosmetic result. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me regarding the outcome of the procedure.

The chance of having a side effect is described by the following categories:

Common - More than 1 our of 100 persons and less than 1 out of 10 persons
Uncommon - More than 1 out of 1,000 persons and less than 1 out of 100 persons

I confirm that my clinician, has:

- Discussed the risks, benefits and alternatives to this treatment as documented in Micro Needling Information Sheet, Version 1, of which I have received a copy
- Given me the opportunity to ask all remaining questions I have about the treatment
- Given me time to consider the treatment
- Received an accurate medical history and that I have not withheld any information
- Discussed and issued me with specific aftercare pertaining to this treatment.

I therefore consent to receiving the described treatment by my clinician.

Date:

Patient Name:

Patient Signature:

Clinician Name:

Clinician Signature: