Viraj V. Tirmal, MD

Viraj V. Tirmal, MD LLC

SCARLET SRF Patient Information and Consent

This document has been prepared to inform you about the SCARLET SRF, RF Microneedling procedure, its risks, precautions, as well as contraindications to the treatment. It is important that you read this information carefully and completely.

Acknowledgement

I, have received information about the proposed treatment. I have discussed my procedure with undersigned medical personnel and have been given an opportunity to ask questions and have them fully answered. I understand the nature and purpose of the recommended procedure, alternative treatment options, possible potential complications/risks and subsequent healing period involved with the proposed procedure. As well, I acknowledge the possibility that additional treatments may be necessary for the desired outcome, and that the procedure may not be successful due to other factors such as health or others that have been explained.

Pre-treatment Precautions
I have received information about the pre-treatment precautions. I am not to use:

- NSAIDs, Blood thinners in 1 week before the treatment
- Chemical peels in 1~6 weeks before the treatment
- LED or non-invasive lasers in 2~3 weeks before the treatment
- Invasive lasers in 6~12 weeks before the treatment
- Use of Retin A, Retinols in 1 month before the treatment
- Hair perm or hair dye in 1 week before treatment

Risks of the Recommended Treatment
As with any medical procedure, there are possible risks associated with the treatment.
I am aware of the following conditions that I am at risk of experiencing:

- **DISCOMFORT**-A slight warming sensation may be experienced during treatment. Areas around the jawline, mouth and eye area can be slightly uncomfortable during when working in that region.
- **USE OF OTHER AGENTS**-A numbing agent will be used to help with any discomfort.
- **REDNESS/SWELLING**-Some redness is common, and can see slight swelling. This is very common and is usually diffused within a few hours or up to 24 hours.
- **SKIN COLOR CHANGES**-Hyper/Hypo pigmentation does not occur with the SCARLET SRF procedure, however any transient UV pigmentation is generally diffused around the surrounding of treated area.
- **SKIN DRYNESS**-Dry skin is common for up to 7 days. It is important to follow the SCARLET SRF post care recommendations to recondition the skin's natural balance quickly.

Contraindications

I am aware of the following contraindications to the suggested treatment of SCARLET SRF.

- Patients with pacemakers, cardioverter defibrillator, or other implanted electrical devices
- Pregnant or breast-feeding mothers
- A current sign or medical history of skin cancer, other cancer types, and/or precancerous warts
- Critically ill patients (i.e. heart-related disease)
- Compromised immune system due to HIV, AIDS and/or drugs that have compromised system
- Heat sensitive diseases, such as herpes simplex
- Endocrine disorders that are hardly manageable such as diabetes
- Patients with progressive acute diseases, eczema, psoriasis, decubitus, rash etc.
- Those with history of impeded recovery from skin disorders, keloid and/or injury
- Patients with impaired blood clotting or who have consumed or injected an anticoagulant drug in the last 10 days
- Those deemed unsuitable for the treatment at the doctors' discretion

I have read and understand this document, and I consent to the treatment proposed for me. I hereby authorize Dr. Viraj Tirmal, or _____ under Dr. Tirmal's supervision to begin my SCARLET SRF treatment.

This consent form is valid for all future Scarlet SRF treatments. I will alert the physician if there are any future changes to my medical history.

_____ _____

Patient Name (print) Date

_____

Address

_____

Signature

Medical Personnel Statement: I have fully explained the nature and purpose of the SCARLET SRF treatment and the potential risks associated with that treatment. I have asked the patient if he/she has any questions regarding the recommended treatment or the risks and have answered those questions to the best of my ability. I also acknowledge that I have read and understand the prescribing information listed above.

_____

Medical Personnel Name (print)

_____

Signature

Submit