CLINICAL TREATMENT CONSULTATION AND CONSENT FORM

BM Pen Clinic:			
BM Pen Practitioner:			
Patient Details			
Full Name			
Date of Birth:			
Address:			
Telephone:	(M)	(H)	(W)

Emergency Contact Details

Full Name			
Relationship			
Telephone:	(M)	(H)	(W)
Email Address:			

WHAT ARE YOUR PRIMARY SKIN CONCERNS THAT YOU WISH TO BE THREATED WITH BM PEN?

DO YOU HAVE ANY IMPORTANT PERSONAL ENGAGEMENTS IN THE NEXT WEEK? ☐ Y ☐ N

DO YOU HAVE ANY KNOWN ALLERGIES? (E.G. LATEX, METALS, SHELLFISH, NUTS, PENICILLIN)

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING ACTIVE SKIN CONDITIONS?

- ☐ Papulopustular Rosacea
- ☐ Acne Vulgaris Stage III-IV
- ☐ Herpes Simplex
- ☐ Warts
- ☐ Scleroderma
- ☐ Bacterial / Fungal / Infections
- ☐ Open Lesions
- ☐ Solar Keratosis
- ☐ Skin Cancer

HAVE YOU EVER EXPERIENCED ANY ADVERSE REACTION TO ANY FORM OF ANAESTHETIC? ☐ Y ☐ N

ARE YOU CURRENTLY UNDER MEDICAL SUPERVISION FOR ANY OF THE FOLLOWING?

- ☐ CARDIAC CONDITIONS
- ☐ DIABETES (type I or II1)
- ☐ HEPATIC DISEASE
- ☐ Hemophilia
- ☐ HUMAN Immunodeficiency Virus (HIV)
- ☐ Cancer
- ☐ AUTO-IMMUNE DISORDER

ARE YOU CURRENTLY PREGNANT OR BREAST FEEDING? ☐ Y ☐ N

ARE YOU CURRENTLY TAKING (OR HAVE TAKEN IN THE LAST 3 MONTHS) ANY OF THE FOLLOWING MEDICATIONS OR SUPPLEMENTS? (PLEASE TICK)

- ☐ Isotretinoin (including but not limited to Roaccutane/Accutane/Isotane
- ☐ Anti-coagulants/blood thinners (including but not limited to Warfarin or aspirin)
- ☐ Contraceptive pill
- ☐ Fish oil/plant oils/omega 3s
- ☐ Photo-sensitizers (including but not limited to anti-depressants/anti-anxieties/antibiotics)
- ☐ Ginseng/gingko biloba/St John's wort

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES IN THE LAST 3 MONTHS ON THE AREA T0 BE TREATED WITH BM PEN? (PLEASE TICK)

- ☐ Plastic/cosmetic surgery
- ☐ Dermabrasion
- ☐ Muscle relaxant injections (including but not limited to Botox or Dysport)
- ☐ Dermal Fillers (including but not limited to Juv derm, Restylane, Esthelis, Radiesse, Aquamid, Sculpta or Artefill)
- ☐ Laser/IPL rejuvenation/hair removal
- ☐ Deep chemical peel
- ☐ Photo dynamic therapy (PDT)
- ☐ Tattooing/cosmetic tattooing

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES IN THE LAST 2 WEEKS ON THE AREA TO BE TREATED WITH BM PEN? (PLEASE TICK)

- ☐ Hair removal (Including but not limited to waxing, plucking, threading or depilatory cream)
- ☐ Chemical peel (Including but not limited to glycolic acid, lactic acid, mandelic acid or salicylic acid)
- ☐ Spray self-tanning
- ☐ Electrolysis/diathermy
- ☐ Microdermabrasion

HAVE YOU USED ANY PRODUCTS CONTAINING ANY OF THE FOLLOWING INGREDIENTS ON THE AREA TO BE TREATED WITH BM PEN IN THE LAST WEEK? (PLEASE TICK)

- ☐ Alpha/beta hydroxy acids (including but not limited to glycolic acid, lactic acid or salicylic acid)
- ☐ Retinoids (Vitamin A) (including but not limited to tretinoin, retinol or retinaldehyde)
- ☐ Benzoyl Peroxide/adapelene (Differin)
- ☐ Hydroquinone/kojic acid/azelaic acid

I,_____, have completed the BM Pen Clinical Consultation & Consent Form honestly and to the best of my knowledge. My BM Pen practitioner has thoroughly explained to me:

- What a BM Pen clinical treatment is
- How a BM Pen clinical treatment works
- BM Pen clinical treatment contra-indications and considerations
- Expected outcomes of my BM Pen clinical treatment
- Anaesthesia protocols
- Post-op care

I understand that a course of BM Pen clinical treatments will be required for optimum results.

Patient Signature: _____

Patient Name: _____

Date: _____

BM Pen Practitioner Signature: _____

BM Pen Practitioner Name: _____

Date: _____