

# Semi-Permanent Make Up PROCEDURE FORMS

Clients Name

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## Introduction

Micropigmentation (commonly known as Semi Permanent Make Up), is a procedure that should only be carried out by a trained specialist using approved equipment to implant coloured pigments into the skin using sterile needles. The treatment requires your full consent and a medical history disclosure as your specialist will need to be sure that you are a suitable candidate for your proposed procedure/s.

Your specialist, Anita Wilson, will describe the benefits and risks of your proposed treatment and record your consultation on this form. This form will be used for reference and referred to on subsequent visits.

**IT IS VITAL THAT YOU CLEARLY MARK AREAS WHICH YOU NEED FURTHER CLARIFICATION OR DISCUSSION TO ENSURE THAT YOU ARE FULLY INFORMED BEFORE YOUR TREATMENT COMMENCES.**

Anita will discuss what the procedure is likely to involve today, and about subsequent treatments. You will be given verbal and written aftercare information.

All details provided will be kept strictly confidential.



## Procedure Consent Form For Semi-Permanent Make-Up

This centre will not perform any procedure on anyone under 18 years of age or under the influence of alcohol or illegal drugs or who is pregnant.

### TO BE COMPLETED BY THE CLIENT

Title: Mr/Mrs/Miss/ Ms.....

Customers Full Name:.....

Address:.....

..... Postcode:.....

Telephone No.:..... Mobile No.: .....

D.O.B ..... Present Age: ..... Occupation:.....

Email:.....

Who may we thank for referring you/ How did you hear of us:.....

Procedure(s) interested in: .....

Procedure reason (please circle):      FASHION      NECESSITY      OTHER .....

Price of treatment(s) £ ..... Method of payment: Cash/ Credit Card/ Cheque

### MEDICATION AND MEDICAL INFORMATION

Are you currently under the care of a doctor or hospital specialist?    YES    NO

If yes, please list the relevant details of your Doctor and condition:

.....  
.....  
.....

Please list any medication you are taking:

.....  
.....  
.....

Do you wear any of the following:      CONTACT LENSES      GLASSES      DENTURES

Do you feel well and able to have the procedure today?    YES    NO

Have you recently undergone, or plan to have, any elective or necessary surgery? YES NO

If yes, please state: .....

Please tick all medical conditions that apply to you:

Pregnant	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Eye Disorder	<input type="checkbox"/>
Hyper pigmentation	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>
Scar heavily or Keloid when injured	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>
Haemophilia	<input type="checkbox"/>	Veneral Disease	<input type="checkbox"/>	Herpes Simplex II	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Dry Eye Syndrome	<input type="checkbox"/>
TB/Lung disease	<input type="checkbox"/>	Iron Deficient	<input type="checkbox"/>	Alopecia	<input type="checkbox"/>
Undergoing Radiation therapy/Chemotherapy	<input type="checkbox"/>	Anaemia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Infectious disease	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	Fainting attacks	<input type="checkbox"/>

Please tick if you are taking any of the following medications:

Accutane	<input type="checkbox"/>	Anabuse	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>
Blood Thinners	<input type="checkbox"/>	Anti-Coagulant	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>

Please tick if you have any of the following allergies:

Anaesthetic. Food or Medicine	<input type="checkbox"/>	Latex	<input type="checkbox"/>
Plasters	<input type="checkbox"/>	Lanolin	<input type="checkbox"/>
Wax Crayons	<input type="checkbox"/>	Carpet Dyes	<input type="checkbox"/>
Metals	<input type="checkbox"/>		

Do you have any imminent holiday plans? YES NO

Do you have or are you planning to have any injectables, fillers or chemical peels? YES NO

Do you suffer from or have any problems with scars healing? YES NO

**I understand the importance of my accurate and complete medical history. And that withholding any medical information may be detrimental to my health and safety during the procedure. I understand that if there is any change in my medical history that it is my responsibility to advise my specialist.**

**SIGNATURE:** ..... **DATE:** .....

It is important to note that if you have an MRI or CAT scan you must tell the radiologist that you have had a medical tattoo. You may experience a slight tingling in the treated area. Pigments are made from iron oxides and are not the same as tattoo inks.



## Allergy (Consent/Waiver) Form

### PATCH TEST WAIVER

I understand that a skin test can determine if I will have a reaction within 24 hours to the products tested but that it is inconclusive regarding whether I will have an allergic reaction at any time in the future. Therefore, I waive my option to an allergy test and wish to proceed with a micropigmentation procedure as soon as possible.

**SIGNATURE:** ..... **DATE:** .....

### PATCH TEST CONSENT

I would like to have an allergy test today. I understand that I could have an allergic reaction to the micropigmentation products within 24 hours. If I do have a reaction I note I may still be able to have a procedure if I have a second allergy test with alternative products.

I understand that if no allergic reaction is evident within 24 hours that it is not to be construed that I may not have a reaction at some time in the future. I affirm that I will release the technician from any liability to an allergic reaction should I wish to proceed with a micropigmentation procedure.

**SIGNATURE:** ..... **DATE:** .....

### IMPORTANT NOTICE

If considering BOTOX or COLLAGEN please note injectables can alter the position of the eyebrows and lipliner.

If considering facial LASER HAIR REMOVAL please ensure you inform the LHR technician that you have had a semi-permanent/micropigmentation lipliner. The reason for this is if laser is done over the vermilion border it can cause the lipline to change colour.

I understand that future laser treatments or other skin altering procedures, such as plastic surgery, chemical peels, implants and injectables may alter my semi-permanent make up.

**SIGNATURE:** .....

I understand that if I have an MRI or CAT scan that I must tell the radiologist that I have iron oxide semi-permanent make up and accept that I may get slight tingling in the treated area.

**SIGNATURE:** .....

**I HEREBY CONSENT TO THE APPLICATION OF MICROPIGMENTATION. I HAVE READ AND UNDERSTOOD ALL POINTS IN THE PROCEDURE CONSENT FORM AND ACCEPT FULL RESPONSIBILITY FOR ANY COMPLICATION THAT MAY ARISE DURING OR FOLLOWING ALL MICROPIGMENTATION PROCEDURES. I ACCEPT THAT NO REFUNDS WILL BE GIVEN FOR INCOMPLETE TREATMENTS OR FOR POOR SATURATION.**

**I HEREBY GIVE MY WRITTEN CONSENT FOR A FINISHING TOUCHES TRAINED TECHNICIAN TO CARRY OUT THE TREATMENT OF MY CHOICE, AS REQUESTED BY ME ON THIS CONSENT AND PROCEDURE AGREEMENT.**

**SIGNATURE:** ..... **DATE:** .....



**TECHNICIAN COMMENTS:**.....

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Your specialist will follow guidelines as outlined in section 15 of the Local Government Act 1982. In addition to this, it is recommended to Finishing Touches trained technicians to use aseptic conditions throughout the treatment.

I absolutely understand that micropigmentation is an art process and is not an exact science and that every client heals differently. I understand that this is an elective procedure and is not medically necessary. I understand that I will need to return for a second treatment before my procedure can be deemed complete. If heavy make-up is required then I accept that I may require additional work, which I understand is chargeable. I understand that the second treatment needs to be taken after 1 month and before 3 months.

**PLEASE SIGNATURE:** .....

If I do not return in the agreed time scale it is deemed that I am happy with a single procedure and that I will pay for any further procedures taken thereafter. I understand that no money will be refunded to me should I decline the second treatment.

**PLEASE SIGNATURE:** .....

I agree to pay the sum agreed (as listed above) at the end of my first treatment today when I am fully satisfied with my procedure.

**PLEASE SIGNATURE:** .....

Lip Procedures Only: I have been explained that should I suffer from the Herpes Simplex virus then I may have a cold sore outbreak. I have been recommended Zovirax (or any other anti-viral medication) or tablets obtainable from my Doctor, which should reduce the risk of an outbreak.

**PLEASE SIGNATURE:** .....

I have undergone/been offered an allergy test prior to my initial treatment and thereby release the technician from any liability related to any allergic reaction or other reaction to applied pigments or other products used after the procedure or at a later date. Pigments are composed of Iron Oxide, Alcohol, Water and Glycerin.

**PLEASE SIGNATURE:** .....

All needles and machine parts used are individually wrapped, sterile and are disposed of after each client. I accept that whilst in the treatment room universal precautions are taken but that my risk of infection begins the moment I leave the centre.

**PLEASE SIGNATURE:** .....

I confirm that I will agree pigment colours and final shape prior to any work commencing and that the technician will keep a log of the colours chosen by myself for my required procedure. All this information will be logged on file to assist with further visits. I fully agree to photographs being taken prior to and after procedure (which will be kept on file and not used for any other purpose, unless I agree in writing).

**PLEASE SIGNATURE:** .....



I accept that after each treatment the area treated may swell or show redness and in some cases bruising. I accept some discomfort. I also accept that the area immediately after treatment will show a colour darker than that chosen – this darker colour will slough and lighten over the following 5-14 days (the healing process varies from person to person depending upon many variables). I accept that should I accidentally pick, pull or knock the treated area then I could get gaps.

**PLEASE SIGNATURE:** .....

I confirm I will strictly adhere to the typed after-care instructions posted/handed to me and only use the after-care products given. I understand that complications are possible, particularly if post-procedure aftercare instructions are not followed and if I get an infection post-procedure I will visit my Doctor immediately and accept that it could be due to the fact that I do not live in sterile conditions. If I have any questions or queries after the procedure I will telephone the technician to discuss.

I fully understand that the skin type of every client is different and have been advised that pigment should stay visible in the skin from 2 to 5 years (and in some cases indefinitely). Also that lighter colours will fade quicker than darker colours, and that colours will change with time. The skin type of every client is different and colour should stay visible in the skin for several years (and in some cases indefinitely). The pigment will be present permanently but will not necessarily be visible. A re-touch procedure will be required periodically to keep the procedure looking fresh. This is dependant on age, skin type and colour chosen.

**PLEASE SIGNATURE:** .....

I understand that when my procedure has been completed the technician will provide me with the opportunity to discuss any immediate concerns and provide me with after care instructions that must be adhered to.

**PLEASE SIGNATURE:** .....



## Photographic/ DVD Release Form

I.....the undersigned, consent that the micropigmentation specialist Anita Wilson, may use any photographs or video footage taken for promotional purposes.

Signed: .....Date: .....

**PRINT NAME:** .....

