
**PRP Hair Restoration Consent Form**

**Treatment:** Platelet Rich Plasma (PRP) hair restoration is thought to stimulate and strengthen existing hair follicles, but it does NOT create new hair follicles or restore follicles that have already died. Thinning hair is believed to benefit from PRP treatments, but PRP is not believed to treat complete baldness. Vial(s) of blood are taken from your arm, which is typically more than normally taken for routine blood tests. The blood is then placed in a vial and spun in a centrifuge to separate the red blood cells and plasma. The process concentrates the platelet count to about many times normal. This platelet rich plasma is subsequently injected into the scalp with the intention of causing regeneration. PRP causes a mild inflammation that triggers the healing cascade. As the platelets organize in the clot they release a number of enzymes to promote healing and tissue responses including attracting stem cells to repair the damaged area. The full procedure takes approximately 1 hour.

**Alternatives:** There are alternative forms to PRP scalp treatments that are non-surgical and surgical. The non-surgical alternatives consist of pharmaceutical therapy such as Propecia, topical treatments such as Rogaine, and homeopathic treatments. The surgical alternatives of aesthetic injectables are Follicular Unit Extraction and FUT (strip procedure). Risks and potential complications are associated with alternative forms of treatment.

**Contraindications:** There are some conditions that prevent PRP injections such as skin diseases (i.e. SLE, porphyria, allergies); Recent/current cancer or chemotherapy; Severe metabolic and systemic disorders; Platelet and blood disorders; Chronic liver pathology; use of anticoagulation therapy; and underlying sepsis

**Potential Risks:** There are risks of using any aesthetic PRP injection. Every cosmetic procedure involves a certain amount of risk, so it is important that you understand the risks involved. An individual's choice to undergo a cosmetic procedure is based on the comparison of the risk to potential benefit.

- Bruising. swelling, or pain at injection sites
- Allergic response or anaphylaxis to anesthetics
- Nerve damage from injections.
- Small risk of infection at injection site, although risk is overall reduced with PRP compared to other injections

**Pre-care Instructions:**

- Avoid NSAID use 1 week prior to procedure (Aleve, Ibuprofen, Naproxen, Advil)
- Avoid coloring hair 2 weeks prior to procedure.
- Please prepare for the procedure by eating a full meal at least 2-3 hours beforehand.
- Drink plenty of fluids the day of and day prior to procedure.
- The procedure typically takes 45 - 60 minutes.

**Post-care Instructions:**

- Avoid NSAID use 1 week after the treatment.
- May use Tylenol (Acetaminophen) or ice following the procedure if needed for pain associated with procedure
- Avoid coloring hair 2 weeks after treatment.
- Please consult with a medical provider regarding use of any steroid medication.



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Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD

**Expectations**:
• For best results 3 - 6 monthly treatments may be required.
• Recommend maintenance treatment every 6-12 months following initial course of treatment

**What to expect after treatments:**
• Lingering soreness of scalp by 24 to 48hrs
• Slowing of hair shedding and gradual hair growth and over next 3-6 months.
• New hair growth is typically noticed after 2nd or 3rd treatment, with maximum effect at 3-9 months following 3rd treatment.
• Treatment effects, with potential for continued improvement, persist 6-12 months after last treatment
• While we cannot guarantee regrowth of new hair, rate of hair loss drastically declines in nearly 100% of patients while receiving treatments and for an average of 6-12 months following the last procedure.

**MEDICAL HISTORY:** I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I am not pregnant or nursing and do not have any contraindication to this procedure.

**FOLLOW-UP TREATMENT:** I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location(s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

**CONSENT TO TREAT:** The procedure has been explained and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

**Initials: _____** I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

**Initials: _____** I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name Printed | Patient Name Signed | Date |
| _____ | _____ | _____ |
| Medical Provider Name Printed | Medical Provider Name Signed | Date |



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