Consent for Hair Transplantation using Follicular Unit Extraction

I, _____, hereby grant permission for Dr. _____ to perform a Follicular Unit Hair Transplantation procedure that includes harvesting the hair via Follicular Unit Extraction (FUE), the administration of anesthetics and sedatives, by oral, intramuscular, or inhalation as may be necessary or desirable to do this procedure for the treatment of hair loss. The procedure has been thoroughly explained to me by the physician, and I fully understand the nature and consequences of the procedure.

These options have been discussed with me and have been fully explained and I understand that there are risks involved in any surgical procedure or treatment.

- I recognize that I have been given every opportunity to ask questions and I have made the decision to go forward clearly understand and agree to the planned surgical procedure.
- **Photography:**

  I understand that routine full face and scalp photographs will be taken for my office file.
- **Driving Caution:**

  I am aware that I will be given medications during and after the surgical procedure that may cause drowsiness and/or impair my judgment. I understand that I will not operate a motor vehicle the day of surgery or at any time while I am under the influence of these medications.
- The procedure, its indications, risks and alternatives have been explained to me by my physician and through the inquiry package and the preoperative instructions. I recognize that during procedure unforeseen conditions can occur that may alter the course and necessitate deviating from the original plan. This may include the transplantation of more or fewer grafts than scheduled.

I hereby authorize and request the surgeon to use his/her professional judgment to complete the FUE Procedure in a manner that will produce the best results in the safest way possible. I have read and understand this consent for FUE Procedure. I have been given the opportunity, by my consultant, to ask questions, and all of my questions have been answered to my full satisfaction. Any objections have been noted or stricken and initialed by me.

This consent was read and signed by me while I was not under the influence of medications or other substances that can cause drowsiness or impair judgment.

I have been told that hair transplantation is a generally safe procedure; however, I realize that following are possible events or complications of FUE that may occur:

• SCARRING:

Every time an incision is made in the human body, a scar will occur, although every effort will be made to make the scar as inconspicuous as possible. Superficial crusting, pinkness, or redness of the incision area will occur, but these

Effects are usually **temporary**. FUE generally leaves small, white 1-mm or below round scars that are not visible unless the hair is cut very short. If the hair is very short, or the scalp is shaved, these scars may become visible. Thickened or raised scars at the excision points are possible. Significant scarring is more likely to occur in people who have had a history of scarring or who have had previous transplants taken from the donor area.

• ANESTHESIA REACTIONS:

Local anesthetics (lidocaine, lignocaine) with Adrenaline (epinephrine) may have effects on many of the body's organ systems, including the heart. Such effects may include allergic reactions, irregular heartbeats, or even, in unusual circumstances, a heart attack. Such risks are uncommon with surgical procedures performed under local anesthesia. Patients on the type of heart or blood pressure medications called "beta-blockers" may be particularly sensitive to epinephrine. Some patients may experience a temporary light-headed episode as a nervous reaction to injections. This reaction may cause a drop in blood pressure and lead to fainting. This condition is easily and relatively rapidly treated. If you are on any heart or blood pressure medication please list below.

Client Signatures_____ Date & Time_____

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I am currently taking_____

I am not on any heart or blood pressure medication _____

• ALLERGIC REACTIONS:

I understand that there may be unusual, unexpected or allergic responses to drugs, medications, suture materials, or foods, prescribed or used during the surgical procedure. I recognize that it is important for the physician to be informed of any problem I, or any member of my family, have had with reactions to drugs and also the medications I have taken in the past six months, including over-the-counter drugs, especially aspirin and any street drugs.

I am allergic to _____

I am not allergic to any drugs, medications, suture materials, or foods. _____.

• STEROIDS:

As discussed, cortisone injections will be used to minimize swelling after the hair transplant. I understand the nature of the cortisone treatment and agree to this preventative treatment.

• FOLLICULITIS:

Folliculitis is an uncommon problem in which hair follicles become infected with bacteria. Folliculitis usually appears in the postoperative period. The associated symptoms include redness around the grafts, pustules around emerging hairs, and itching. There may be some associated loss of hair in the involved follicles, but since the problem is localized to individual hair follicles, the loss is rarely significant from a cosmetic standpoint. The treatment consists of oral antibiotics that may be given for an extended period of time. With FUE, Folliculitis can occur if the grafts are pushed into the fat and not retrieved during the procedure. These grafts can incite an inflammatory reaction and may require removal at a later date through a small incision.

Note: In case of refunds, refunded amount will be issued within 10 working days.

• HAIR LOSS:

There may be **temporary** hair shedding in the back of the scalp in the area where the donor hair is removed. This hair will generally grow back. Hair that is removed through the follicular extraction process will not return to its full extent in the transplanted area, you may experience shedding of your existing hair following the surgery (a process called telogen effluvium). If this hair is at or near the end of its normal life span (miniaturized hair), it may not return. Because genetic balding is a continuous process, you may continue to lose more hair over time. If this occurs, a subsequent hair transplant procedure may be desired.

• HAIR TEXTURE CHANGES:

When your new hair begins to grow it may be more kinked or wavier than your original hair. Over time the hair generally resumes its normal character. It is possible that these hair texture changes may persist.

• SMOKING:

Smoking causes constriction of blood vessels and decreased blood flow to the scalp, predominantly due to its nicotine content. The carbon monoxide in smoke decreases the oxygen carrying capacity of the blood. These factors may contribute to poor wound healing after a hair transplant and can increase the chance of a wound infection and scarring. Smoking may also contribute to poor hair growth. The deleterious effects of smoking wear off slowly when one abstains, particularly in chronic smokers, so that smoking puts one at risk to poor healing even after smoking is stopped for weeks or even months. Although it is not known exactly how long

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One should avoid smoking before and after a hair transplant a common recommendation is to abstain from 1 week prior to surgery to 2 weeks after the procedure.

- **SUN DAMAGED SKIN:**

After your transplant, you must still protect your scalp from the damaging rays of the sun. Your new hair makes close observation of your scalp important because unusual new skin growths, or skin changes, may be more difficult to see. In addition, if you have a history of skin cancer or sun damaged sun damaged skin, you should be followed by your dermatologist. It is possible that significantly sun damaged skin may hinder hair growth.

- **INFECTION:**

The symptoms of infection include swelling, redness, tenderness or puss at the surgical site and may be associated with fever or chills. If you experience any of these symptoms, contact us at once.

- **OTHER:**

There may be temporary swelling, discoloration, or bruising associated with the procedure. There may be the formation of a cyst at a graft site, ingrown or buried hairs, hematoma (localized blood clot), or rejection of a graft In areas of scar tissue, grafts may grow poorly or not at all.

Cosmetic Surgery Guarantee:

For all hair transplantation procedures performed by our team of surgeons, we guarantee to replace any non-growing hair transplant graft free-of-charge, providing only that the patient has adequate donor in our experience, such replacement has seldom been necessary.

Note: There will be 2 copies of consent (1 copy for the patient and 1 copy for the clinic)

_____ _____
Signature of Physician **Date & Time**

_____ _____
Signature of Patient **Date & Time**

_____ _____
Signature of legal Guardian **Date & Time**
(*If the patient is a minor or is capable of consenting, signature of nearest relative or legal guardian*)

_____ _____
Signature of the interpreter **Date & Time**

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ACKNOWLEDGEMENT

The following is to confirm that we have discussed with you the nature of your condition, the proposed treatment thereof, the prospects for success and the limited risks of potential side effects associated with such treatment/s. As per current medical knowledge any potential side effects resulting from our treatments are reversible and temporary in nature.

By signing this form, you confirm and consent to the following:

1. My medical condition and the proposed treatment have been explained to me. I have been advised that although good results are expected, the possibility and nature of complications cannot be accurately anticipated and therefore, there can be no guarantee, either expressed or implied as to the success or other result of treatment.

2. The potential side-effects of the treatment being idiosyncratic reactions (reactions specific to an individual), such as: bruising, temporary pain and itching, redness, infection, onset of herpes, onset of acne, burning and blistering, fat necrosis, facial nerve affection, unsatisfactory cosmetic result, extrusion, swelling, transient skin discoloration, allergic reaction, and reversible brow or eyelid ptosis, have been explained to me.

3. I declare that while completing the medical questionnaire, I have answered the information related to my personal medical history questions completely and I have not withheld any information.

I have consulted with the physician or therapist (depending on the nature of treatment) who will be treating me and all my questions concerning the treatment have been answered to my satisfaction. I fully understand all of the above and thereafter, I consent to the proposed treatment/s:

_____ _____

Signature of Patient **Date & Time**

_____ _____

Signature of legal Guardian **Date & Time**

(*If the patient is a minor or is capable of consenting, Signature of nearest relative or legal guardian*)

_____ _____

Signature of the interpreter **Date & Time**

DEPOSIT AND PAYMENT POLICY:

We require a full/ partial payment before your surgery to hold your appointment .It will be credited toward the procedure fee on the day of your procedure. We honor Visa and Master Card and Cash payment. You can also mail your full/partial payment in the form of a personal cheque, cashier's cheque or money order to **B R Medical Suites Cosmetic Surgery**. Until your full/partial payment is received, the date you have chosen is still considered open and may be taken by another patient. This policy is necessary, a surgical room reserved for the time of surgery. If a patient does not keep his/her scheduled appointment this surgery full payment is usually **non-refundable and the dates are not changeable.** Payment is due in full on the day of surgery and can be made by cash or credit card.

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