KELOID / SCAR TREATMENT CONSENT FORM

(Using Intralesional Injection / Laser / Microneedling / PRP Method)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____

1. Procedure Description

Keloid and scar treatment may involve intralesional injections (such as steroids or PRP), laser therapy, microneedling, or a combination of these methods. The goal is to reduce the thickness, hardness, and discoloration of the scar or keloid, and to improve the appearance and texture of the skin.

2. Purpose of Procedure

The purpose of this treatment is to soften, flatten, and lighten keloid or hypertrophic scars, and to reduce associated symptoms such as itching, pain, or tightness.

3. Possible Risks and Side Effects

I understand that the following risks and side effects may occur:
- Redness, swelling, or mild discomfort at the injection or treatment site.
- Temporary pigmentation changes (darkening or lightening of skin).
- Mild bruising or small scabs may form.
- Infection, although rare, can occur if post-care instructions are not followed.
- Recurrence or regrowth of the keloid or scar is possible even after multiple sessions.
- Rarely, thinning of the skin or visible capillaries (after steroid injections).

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Inform your doctor of any medications, allergies, or history of bleeding disorders.
- Avoid taking blood thinners or anti-inflammatory drugs unless prescribed.

Post-Procedure:

- Keep the treated area clean and dry for 24 hours.
- Avoid scratching, rubbing, or applying makeup on the area immediately after the procedure.
- Apply prescribed ointment or soothing cream as advised.
- Protect the area from sun exposure; use sunscreen regularly.
- Follow up as advised for repeat sessions for best results.

5. Acknowledgment

I acknowledge that the nature, purpose, benefits, and risks of keloid/scar treatment have been explained to me. I understand that multiple sessions may be required and complete resolution cannot be guaranteed. I have had the opportunity to ask questions and all my doubts have been clarified. I voluntarily consent to undergo this treatment.

6. Consent

Patient Name: _____

Signature: _____ Date: _____

Witness Name: _____

Signature: _____ Date: _____

Doctor's Name & Signature: _____