PRP (PLATELET RICH PLASMA) FACIAL & HAIR TREATMENT CONSENT FORM

(For Skin Rejuvenation and Hair Growth Stimulation)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____

1. Procedure Description

PRP (Platelet Rich Plasma) therapy involves drawing a small amount of the patient's own blood, processing it to concentrate platelets, and re-injecting the plasma into the skin or scalp. In facial PRP, the plasma helps improve skin texture, fine lines, and glow. In hair PRP, it stimulates dormant hair follicles to promote thicker and healthier hair growth.

2. Purpose of Procedure

The goal of PRP treatment is to naturally rejuvenate the skin and stimulate hair growth using the body's own healing factors. Multiple sessions are typically recommended for visible and lasting results.

3. Possible Risks and Side Effects

I understand that the following risks and side effects may occur:
- Mild redness, swelling, or bruising at the injection site.
- Temporary tenderness, itching, or tightness in the treated area.
- Minimal bleeding or formation of small scabs.
- Rare chance of infection, allergic reaction, or injury to small blood vessels.
- Mild headache or sensitivity after scalp injections.
- Results may vary depending on individual response.

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Avoid blood-thinning medications (aspirin, ibuprofen, alcohol) for 2–3 days prior, unless prescribed by a doctor.
- Drink plenty of water before your session.
- Wash hair and face thoroughly on the day of the procedure; avoid using any creams or makeup.

Post-Procedure:

- Do not touch, rub, or wash the treated area for 6–8 hours.
- Avoid gym, swimming, sauna, or sun exposure for 24–48 hours.

- Do not use hair oil, dye, or chemical treatments for 5–7 days post-procedure.
- Apply prescribed soothing cream or serum if advised.
- Follow the recommended session plan (usually 3–6 sessions at monthly intervals).

5. Acknowledgment

I acknowledge that the nature, purpose, and expected benefits of PRP facial and hair treatment have been explained to me. I understand that multiple sessions are required and results may vary based on individual conditions. I am aware of possible side effects and downtime. I voluntarily consent to undergo this procedure.

6. Consent

Patient Name: _____

Signature: _____ Date: _____

Witness Name: _____

Signature: _____ Date: _____

Doctor's Name & Signature: _____