CONSENT FORM FOR SCAR REVISION PROCEDURE

Clinic Name: _____ **Date:** _____
Doctor Name: _____
Patient Name: _____

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1. **PROCEDURE DESCRIPTION:**
   I, the undersigned, voluntarily consent to undergo a **Scar Revision procedure**. The procedure aims to improve the appearance of scars using techniques such as laser therapy, surgical excision, dermabrasion, or injectable treatments.

2. **POTENTIAL RISKS & COMPLICATIONS:**
   I understand that while scar revision is generally safe, there are potential risks and complications, including but not limited to:

   - Redness, swelling, or irritation at the treatment site
   - Infection or delayed wound healing
   - Temporary or permanent pigmentation changes
   - Scar recurrence or worsening of the existing scar
   - Need for multiple sessions for optimal results
   - Allergic reaction to anesthetics or medications used

3. **CONTRAINDICATIONS:**
   I confirm that I have disclosed any medical conditions that may affect the outcome of the procedure, including but not limited to:
   - Active skin infections or open wounds
   - History of keloid or hypertrophic scars
   - Use of blood thinners or other medications that affect healing
   - Pregnancy or breastfeeding

4. **ALTERNATIVE TREATMENTS:**
   I have been informed of alternative treatment options for scar improvement and understand that I have the option to decline treatment.

5. **POST-PROCEDURE CARE & FOLLOW-UP:**
   I understand that proper aftercare is essential and agree to:
   - Keep the treated area clean and follow wound care instructions
   - Avoid sun exposure and apply sunscreen regularly
   - Refrain from picking or scratching the treated area
   - Attend follow-up appointments as advised by my doctor

6. **CONSENT TO PHOTOGRAPHY (Optional):**
   I give permission for my photographs to be taken for medical records and treatment monitoring purposes. These images will remain confidential.
   [ ] Yes, I consent
   [ ] No, I do not consent

7. **INFORMED CONSENT & ACKNOWLEDGEMENT:**
   I have read and fully understand the information provided in this consent form. I have had the opportunity to ask questions, which have been answered to my satisfaction. By signing below, I acknowledge that I am making an informed decision to undergo this procedure.

Patient Signature: _____ **Doctor Signature:** _____

Date: _____ **Date:** _____

Witness (if applicable): _____

Date: _____