

STRETCH MARK REDUCTION CONSENT FORM

(Using Microneedling / MNRF / PRP / Laser / Chemical Peel Methods)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____



1. Procedure Description

Stretch mark reduction treatment involves the use of microneedling, microneedling radiofrequency (MNRF), fractional laser, PRP therapy, or chemical peels to stimulate collagen production and improve skin elasticity. These procedures help reduce the depth, width, and color of stretch marks over multiple sessions.

2. Purpose of Procedure

The purpose of the treatment is to lighten and smoothen the appearance of stretch marks, improve skin tone, and restore firmness to the affected area. Complete removal of stretch marks is not guaranteed, but significant improvement can be achieved with regular sessions.

3. Possible Risks and Side Effects

I understand that the following risks and side effects may occur:

- Redness, swelling, or mild discomfort after the procedure.
- Temporary dryness, peeling, or flaking of the treated skin.
- Mild bruising or tenderness (especially after PRP or MNRF).
- Post-inflammatory pigmentation (temporary darkening of skin).
- Rare chance of infection, scarring, or allergic reaction.
- Gradual improvement; results may vary depending on skin type and stretch mark severity.

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Avoid applying active creams (like retinoids or exfoliants) for 3–5 days prior.
- Inform your doctor about any ongoing medications or skin allergies.
- Avoid direct sun exposure and chemical peels before the session.

Post-Procedure:

- Keep the treated area clean and moisturized as directed.
- Avoid gym, swimming, and sauna for 2–3 days post-procedure.
- Do not scratch or rub the area; allow natural healing.

- Use sunscreen regularly to protect treated areas.
- Follow up for recommended number of sessions for optimal results.

5. Acknowledgment

I acknowledge that the nature, purpose, and expected benefits of the stretch mark reduction procedure have been explained to me. I understand that multiple sessions are required and results may vary. I have been informed about possible risks, side effects, and post-care instructions. I voluntarily consent to undergo this treatment.

6. Consent

Patient Name: _____

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Signature: _____

Date: _____

Witness Name: _____

Signature: _____

Date: _____

Doctor's Name & Signature: _____

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