VAMPIRE FACIAL CONSENT FORM

(PRP with Microneedling for Skin Rejuvenation)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____

1. Procedure Description

A Vampire Facial, also known as PRP Microneedling, involves the use of your own platelet-rich plasma (PRP) combined with microneedling to stimulate collagen production and improve skin tone, texture, and elasticity. A small amount of your blood is drawn, processed to extract PRP, and then applied and infused into the skin through controlled microneedling.

2. Purpose of Procedure

The purpose of this treatment is to rejuvenate the skin, minimize fine lines and wrinkles, reduce acne scars, and enhance overall glow and firmness using the body's natural healing factors.

3. Possible Risks and Side Effects

I understand that the following risks and side effects may occur:
- Redness, swelling, or mild discomfort post-procedure.
- Temporary tightness, dryness, or peeling of the skin.
- Mild bruising at the site of blood draw or treated areas.
- Post-inflammatory hyperpigmentation (temporary darkening).
- Rare chance of infection, scarring, or prolonged redness.
- Individual results may vary; multiple sessions may be required.

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Avoid alcohol, caffeine, and blood-thinning medications for 24–48 hours prior.
- Discontinue use of retinoids, acids, or exfoliating products 3–5 days before treatment.
- Drink plenty of water to stay hydrated.

Post-Procedure:

- Do not wash or touch the treated area for at least 6–8 hours.
- Avoid makeup, gym, swimming, and direct sunlight for 48 hours.
- Use only prescribed gentle cleanser and soothing moisturizer.

- Apply sunscreen (SPF 30+) daily to protect the treated skin.
- Mild redness may persist for 1–3 days; avoid picking or scratching.

5. Acknowledgment

I acknowledge that the nature, purpose, and potential risks of the Vampire Facial have been explained to me. I understand that multiple sessions may be needed for optimal results. 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: _____