Patient Consent

Bella Voi Pantiles Clinic

Please complete all details required on this form as noted by your consultant. Please make sure you read through all information thoroughly and sign and date at the bottom of the relevant areas.

PROCEDURE DETAILS
Proposed procedure(s)
Purpose of proposed procedure(s)
Specialist / Consultant name

PERSONAL DETAILS	
Title	First name
Middle name(s)	Surname
DOB	Preferred name
Address	Home phone no
	Evening phone no
Town	Mobile phone no
County	Email address
Postcode	

OTHER NOTES

I confirm that I have read, understood and have taken time to consider all of the identified risks as described above. I have also had the opportunity to discuss any additional concerns and questions with my surgeon. I have decided to proceed with stated procedure with full knowledge of the risks and intended benefits involved. I certify that I have fully informed my surgeon correctly and to the best of my knowledge of my full medical history and status, and that I understand withholding medical information could lead to complications or problems that may have been prevented if that information were known prior to my surgery.

IMPORTANT: Signature must be signed below **AND** in all relevant boxes on right side of page.

PRINT NAME *(PATIENT)*	**PRINT NAME** *(CLINICIAN)*
SIGNED *(PATIENT)*	SIGNED *(CLINICIAN)*
DATE	DATE

CONCEPT™FACELIFT

- ☐ Scaring
- ☐ Bleeding
- ☐ Swelling
- ☐ Infection
- ☐ Wound breakdown
- ☐ Asymmetry
- ☐ Under or over correction
- ☐ Numbness
- ☐ Damage to the facial nerve
- ☐ Ear pain
- ☐ Seroma
- ☐ Pixie ear deformity

OTHER RISK / COMPLICATIONS:

☐
☐
☐

SIGNED **DATE** / /

NECK LIFT

- ☐ Scaring
- ☐ Bleeding
- ☐ Swelling
- ☐ Infection
- ☐ Wound breakdown
- ☐ Under or over correction
- ☐ Numbness
- ☐ Seroma
- ☐ Skin necrosis
- ☐ Pain

OTHER RISK / COMPLICATIONS:

☐
☐
☐

SIGNED **DATE** / /

UPPER / LOWER EYELID SURGERY

- ☐ Watery Eyes
- ☐ Injury to the surface of the eye
- ☐ Scarring
- ☐ Bleeding
- ☐ Swelling
- ☐ Infection
- ☐ Wound breakdown
- ☐ Asymmetry
- ☐ Under or over correction
- ☐ Pain
- ☐ Dry eyes

OTHER RISK / COMPLICATIONS:

☐
☐
☐

SIGNED **DATE** / /

HAIR TRANSPLANT

- ☐ Scarring
- ☐ Swelling
- ☐ Mild 'shocking' shedding of existing hair
- ☐ Numbness
- ☐ Bleeding
- ☐ Infection
- ☐ Wound breakdown
- ☐ Irregular, delayed hair growth
- ☐ Epidermoid cysts

OTHER RISK / COMPLICATIONS:

☐
☐
☐

SIGNED **DATE** / /

LIP ENHANCEMENT

- ☐ Swelling
- ☐ Scarring
- ☐ Bleeding
- ☐ Bleeding
- ☐ Infection
- ☐ Numbness
- ☐ Under or over correction

OTHER RISK / COMPLICATIONS:

☐
☐
☐

SIGNED **DATE** / /

OTHER *(SPECIFY)*

☐
☐
☐
☐
☐
☐
☐

SIGNED **DATE** / /

IMPORTANT: Signature must be signed in all relevant boxes above **AND** on left side of page.
TOP COPY FOR CLINIC, BOTTOM COPY FOR PATIENT