# Hair Restoration Consent (PRP / Transplant)

Informed consent for hair restoration treatments including PRP scalp injections, microneedling, and follicular unit extraction procedures

## Client Information

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

MM / DD / YYYY

## Treatment Details

Treatment *

- [ ] PRP scalp injections
- [ ] PRP with microneedling
- [ ] Follicular unit extraction (FUE) transplant
- [ ] FUE eyebrow / beard transplant
- [ ] Exosome or growth-factor therapy
- [ ] Other

Areas *

- [ ] Crown
- [ ] Hairline / Temples
- [ ] Diffuse thinning
- [ ] Eyebrows
- [ ] Beard
- [ ] Scar coverage

How long have you noticed hair loss? *

- [ ] Under 1 year
- [ ] 1–5 years
- [ ] More than 5 years

Has a physician diagnosed the cause of your hair loss? *

- [ ] Yes
- [ ] No

Treatments tried so far (minoxidil, finasteride, supplements, prior PRP or transplant)

## Medical History

Are you pregnant, trying to conceive, or breastfeeding? *

- [ ] Yes
- [ ] No

Do you have any of the following?

- ☐ Autoimmune condition (lupus, RA, MS, etc.)
- ☐ Bleeding disorder or on blood thinners
- ☐ Diabetes
- ☐ History of keloid or hypertrophic scarring
- ☐ Cancer (current or within the last 5 years)
- ☐ Immunosuppressed / immune disorder
- ☐ None of the above

Do you have an active scalp infection, psoriasis, folliculitis, or open wounds? *

☐ Yes ☐ No

Do you have alopecia areata, scarring alopecia, or an autoimmune hair condition? *

☐ Yes ☐ No

Do you have a platelet or blood disorder, or are you on anticoagulants? *

☐ Yes ☐ No

Have you taken isotretinoin (Accutane) in the last 6 months? *

☐ Yes ☐ No

Do you smoke or vape nicotine? *

☐ Yes ☐ No

Are you pregnant or breastfeeding? *

☐ Yes ☐ No

Current medications and supplements

Allergies (medications, latex, lidocaine, anesthetics)

## Risks & Complications

Potential Risks and Complications:

- Scalp tenderness, swelling, and bruising for several days; forehead swelling after hairline treatment
- Bleeding at injection or extraction sites
- Infection or folliculitis
- Temporary shedding of existing hair (shock loss) 2–8 weeks after treatment, usually recovering
- Numbness or altered sensation of the scalp, usually temporary
- Small dot scars in the donor area after FUE; visible thinning of the donor area if over-harvested
- Poor graft survival, unnatural hairline, or uneven density requiring further sessions
- Cysts or ingrown hairs at graft sites
- No response — PRP results vary and require a series of 3–4 sessions plus maintenance; hair loss continues in untreated areas

Results take 3–6 months (PRP) or 9–12 months (transplant) to become visible.

I understand that hair restoration results are gradual, vary between individuals, may require a series of treatments and ongoing medical therapy, and that no specific density or coverage has been guaranteed.

I understand results vary and take months: _____

I understand the risks of bleeding, infection, shock loss, scarring, numbness, and poor graft survival, and that I have disclosed all medications, scalp conditions, and nicotine use.

I understand the surgical and injection risks: _____

## Photo Release

May we take before-and-after photos for your treatment record? *

- ☐ Yes — for my medical record only
- ☐ Yes — and you may use them anonymously for marketing
- ☐ No

## Service Log

For office use only

| | Date | Area | Treatment / Grafts / Volume | Notes |
|---|---|---|---|---|
| Entry 1 | | | | |
| Entry 2 | | | | |
| Entry 3 | | | | |
| Entry 4 | | | | |
| Entry 5 | | | | |
| Entry 6 | | | | |

## Consent & Signature

I voluntarily consent to the hair restoration treatment selected above. I have been informed of the benefits, risks, alternatives (including medical therapy and no treatment), and potential complications. I understand this is an elective procedure and no guarantee of outcome has been made. I release the provider and practice from liability related to this treatment except in cases of negligence.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

Signature

Date

Print name

Date *

MM / DD / YYYY