PRP / Vampire Facial Consent

Informed consent for Platelet Rich Plasma therapy and PRP microneedling treatments

Client Information

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

MM / DD / YYYY

Treatment Details

PRP Treatment Type *

- [ ] PRP Facial (Vampire Facial — PRP + Microneedling)
- [ ] PRP Injections (joint, scalp, or skin)
- [ ] PRP Hair Restoration

Treatment Areas *

- [ ] Face
- [ ] Neck
- [ ] Scalp
- [ ] Under Eyes
- [ ] Hands
- [ ] Joint (specify)

Health Screening

Are you currently pregnant or nursing? *

- [ ] Yes
- [ ] No

Do you have a bleeding disorder or platelet dysfunction? *

- [ ] Yes
- [ ] No

Are you taking blood thinners or NSAIDs (aspirin, ibuprofen)? *

- [ ] Yes
- [ ] No

Do you have any active skin infections or cold sores in the treatment area? *

- [ ] Yes
- [ ] No

Do you have any active cancer or blood-borne diseases? *

- [ ] Yes
- [ ] No

Have you taken Accutane in the past 6 months? *

- [ ] Yes
- [ ] No

Risks & Expected Recovery

About PRP Treatment:
PRP uses your own blood, which is drawn, processed in a centrifuge to concentrate platelets, and then applied to the skin via microneedling or injected into target areas.

Potential Risks:
- Bruising, redness, and swelling at blood draw and treatment sites
- Pain or discomfort during treatment
- Infection (rare)
- Allergic reaction to numbing cream (PRP itself uses your own blood)
- Temporary hyperpigmentation
- Nodules at injection sites (rare)
- Results vary — multiple sessions typically needed

Aftercare:
- Avoid touching treated area for 6 hours
- No makeup for 24 hours
- Avoid sun, exercise, sauna for 48 hours
- No retinoids or exfoliants for 72 hours
- Keep skin hydrated

I understand that PRP involves a blood draw and the risks associated with both the draw and the treatment. I consent to proceed.

I understand the risks and blood draw procedure: _____

Service Log
For office use only

	Date	Step	Detail	Notes
Entry 1				
Entry 2				
Entry 3				
Entry 4				
Entry 5				
Entry 6				

Consent & Signature

I consent to the PRP treatment described above, including the blood draw. I understand the risks, benefits, and alternatives. I have disclosed all relevant health information. I release the provider from liability.

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