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CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
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CONSENT for DERMAPLANING

Patient Name: Date:

DERMAPLANING *is a procedure using a sterile surgical blade to scrape the superficial dead skin cells and villous hair from the surface of the skin.*

I AM AWARE OF THE FOLLOWING POSSIBLE SIDE EFFCTS WITH DERMAPLANING:

DISCOMFORT - If discomfort is experienced, simply inform the technician and adjustments will be made.

WOUND HEALING – This is generally not an issue, as no open wound exists. In the advent of an aggressive treatment, bruising and inflammation may occur.

BRUISING/SWELLING/INFECTION – Bruising and swelling generally are non-existent since only the uppermost part of skin layers are treated. Skin infection is a slight possibility any time a skin procedure is performed.

PIGMENT CHANGES (Skin Color) – Since Dermaplaning is generally the removal of the stratum corneum (the uppermost level of the skin), pigment changes are unlikely. However depending on the depth within the skin, there is always a risk.

SCARRING – Scarring is a rare occurrence, but it is possible where the skin surface is disrupted. To minimize the changes of scarring, it is important that you follow all post-operative instructions carefully.

NICKS – Nicking the skin can sometimes occur with Dermaplaning and will appear like small paper cuts on the skin. Healing time generally takes 1-3 days with minimal discomfort.

LINES/STREAKING – Although uncommon, you may have temporary lines or streaking of the skin which could last for several days.

HERPES SIMPLEX BLISTERS/COLD SORES – If you have a history of herpes simplex or cold sores, a reactivation of this condition can occur over the treated area.

Acknowledgements:

- *I UNDERSTAND THAT DERMAPLANING MUST BE DONE REGULARLY IN ORDER TO ACHIEVE OPTIMAL RESULTS.*
- *I UNDERSTAND THAT IT IS EXTREMELY IMPORTANT TO STRICTLY FOLLOW ALL HOME CARE INSTRUCTIONS WHEN STRIVING FOR OPTIMAL RESULTS.*
- *I UNDERSTAND THAT IF I EXPERIENCE ANY ADVERSE SIDE EFFECTS THAT APPEAR TO BE ATTRIBUTED TO MY USE OF HOME CARE PRODUCTS THAT I NEED TO DISCONTINUE USE OF THESE PRODUCTS AND NOTIFY THE TECHNICIAN/NURSE/SPECIALIST.*

Patient (Print Name)	Signature	Date
Witness (Print Name)	Signature	Date