



# KESPRA MEDICAL CENTER

22 Meridian Rd, Suite 10 Edison, NJ 08820

## PLATELET RICH PLASMA (PRP) INFORMED CONSENT

I \_\_\_\_\_ have been advised and consulted about the injection technique of platelet rich plasma.

I have been advised that platelet rich plasma is an established treatment techniques used to tighten and strengthen weak and damaged ligaments and tendons which are believed to cause pain and instability. It is also used to decrease pain and improve function in some forms of arthritis.

The technique requires the injection of Platelet Rich Plasma derived from my own blood according to standard blood collection and injection techniques. The site of injection is where the ligament or tendon attaches to the bone, at the joint capsule, or inside the joint.

I have been informed that the procedure has been used on many patients and has been proven safe. The procedure may initially increase the painful area or reproduce symptoms for one to three days (and occasionally, as long as ten days), and then may decrease in intensity, but may not completely eliminate my symptoms.

I understand that some insurance companies have determined this treatment to be experimental due to the lack of large research studies in the scientific literature. I understand the benefits of the procedure are improved or resolved pain and improved function.

I have been informed that the alternatives to PRP are:

- Do nothing
- Surgical intervention may be a possibility
- Injection with steroids (not long lasting results)
- Manipulation may provide temporary pain relief
- Acupuncture

I have been informed that the risks and complications of PRP are:

- Immediate pain at the injection site
- Stiffness in the injected joint
- Bruising
- Allergic reaction
- Infection
- Nerve or muscle injury
- Nausea
- Dizziness or fainting
- Swelling after joint injections



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- Bleeding
- Temporary blood sugar increase
- Itching at injection site

I have been informed that the risks of not having treatment are:

- No relief of pain
- Continued instability of the damaged joint or ligament and probable worsening of pain.

I HAVE READ (OR HAVE HAD READ TO ME) THE ABOVE CONSENT. **[KESPRA MEDICAL CENTER]** HAS EXPLAINED THE PROCEDURE(S) TO ME SO THAT I FULLY UNDERSTAND IT (THEM). NO GUARANTEE OF SUCCESSFUL TREATMENT HAS BEEN IMPLIED. I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS CONSENT FORM UPON REQUEST.

I understand that this procedure is usually not covered by insurance and I am responsible for the total charges.

\_\_\_\_\_

Parent or Legal Guardian

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Witness

\_\_\_\_\_

Date

\_\_\_\_\_

Representative



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## Micro Needling Patient Consent Form

### Description of the Procedure:

The [enter product name] skin needling system or dermal roller treatment allows for controlled induction of the skin's self-repair mechanism by creating micro "injuries" in the skin which triggers new collagen synthesis. The result is smoother, firmer and younger looking skin.

Skin needling procedures are performed in a safe and precise manner with the use of the sterile [enter product name] skin needling system or dermal roller treatment. The procedure is normally completed within 30-60 minutes depending on the required treatment and anatomical site.

### Side Effects:

After the procedure, the skin will be red and flushed in appearance in a similar way to moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. The skin's redness will diminish greatly after a few hours following the treatment and within the next 24 hours the skin will be generally calmed. After 3 days the skin will return to a normal or near normal appearance.

### Contraindications:

Keloid scars; history of eczema, psoriasis and other chronic conditions; history of actinic (solar) keratosis; history of Herpes Simplex infections; history of diabetes; presence of raised moles, warts on targeted area. Other medical at risk conditions based upon your medical history may also contraindicate yourself from receiving treatment.

Absolute contraindications include; scleroderma, collagen vascular diseases or cardiac abnormalities; blood clotting problems; active bacterial or fungal infection; immunosuppression; scars less than 6 months old. Not recommended for women who are pregnant or nursing.

### Patient Consent:

I understand that results will vary between individuals. I understand that although I may see a change after my first treatment; I may require a series of sessions to obtain my desired outcome.

The procedure and side effects have been explained to me including alternative methods; as have the advantages and disadvantages. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment.



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I am aware that the [enter product name] skin needling system or dermal roller treatment is not permanent as natural degradation will occur over time. I state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it.

I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner.

**THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.**

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_