truSculpt® iD

HAMILTON COSMETIC DERMATOLOGY

PATIENT INFORMED CONSENT FORM

I hereby authorize Dr. Tatyana Hamilton, MD, FRCP or _______________, under Dr Tatyana Hamilton, MD, FRCP's supervision to treat me with the truSculpt device. I understand that this procedure works by using radio frequency (RF) energy to provide uniform deep tissue heating for the purpose of elevating tissue temperature for the treatment of selective medical conditions. Additionally, the 2 MHz setting for the 40 cm2 handpiece can be used for reduction in circumference of the abdomen and non-invasive lipolysis (breakdown of fat) of the abdomen. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT/PAIN –** Moderate discomfort during treatment is expected. Mild discomfort or slight tenderness in the treatment area may persist for a few hours following treatment, potentially extending to a few days.
- **REDNESS/SWELLING/BRUISING –** Short term redness (hyperemia) is expected following treatment and typically persists for several hours. In addition, swelling (edema) and/or bruising of the treated area may occur and typically resolve within 24 hours to a few days.
- **BRUISING/PETECHIAE OUTSIDE THE TREATMENT AREA** - May occur under the area where the decal is applied and can occur in the process of removing the decal from patient's skin.
- **LUMPS -** Firm edemic areas may develop in the treated area 24 to 72 hours following treatment, and typically resolve without intervention over several weeks. If lumps do develop, they are typically tender to touch.
- **WOUNDS –** Treatment can result in burning, blistering, crusting, scabbing or bleeding of the treated areas or under the return pad. If any of these occur, please call our office at 250-940-8000.
    - **INFECTION –** Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office at 250-940-8000. It is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
    - **SCARRING –** Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
    - **SKIN COLOR CHANGES –** If the skin surface is disrupted, there is a possibility that the area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- **NUMBNESS –** Temporary numbness may occur, but is rare.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period

Certain people are not candidates for this procedure (contraindicated) or are at a higher risk for complications. All treatment contraindications, precautions and warnings have been discussed with me.

By signing below, I confirm that I have informed Dr. Tatyana Hamilton, MD, FRCP of all implanted devices, including metallic implants, electronic implants, time-released medical implants and superficially placed body contouring implants.

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By signing below, I confirm that I do not have a cardiac implant (including defibrillator/pacemaker). Furthermore, I agree to keep Dr. Tatyana Hamilton, MD, FRCP and staff informed should I have a defibrillator/pacemaker, or any cardiac device implanted. I understand that this procedure should not be performed on patients who have a cardiac implant (including defibrillator/pacemaker).

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. Tatyana Hamilton, MD, FRCP and staff informed should I become pregnant during the course of treatment. I understand that this procedure should not be performed on patients who are pregnant.

Photographic documentation will be taken. I hereby ☐ do ☐ do not authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT
BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE TRUSCULPT PROCEDURE, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

______________________	______________________	______________________
Signature-Patient	**Print Name**	**Date**
______________________	______________________	______________________
Signature-Witness	**Print Name**	**Date**

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