

## Consent for Rejuran (polynucleotide) treatment

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Treating practitioner name: \_\_\_\_\_ Provider no.: \_\_\_\_\_

Treatment date: \_\_\_\_\_

Treatment location: Victorian Cosmetic Institute Level 1, 268 Manningham Road, Lower Templestowe 3107.

I understand this treatment is **elective and cosmetic**, and not medically necessary.

I have been informed of **other options**, including not proceeding.

I understand some products or treatment areas may involve **off-label use** (outside TGA-approved indications).

I accept that **results vary**, are not guaranteed, and may not be long-lasting.

I understand that **medical information evolves**, which may affect future understanding of benefits and risks.

I have disclosed any relevant **medical conditions or contraindications** to my practitioner.

**Clinical photographs** may be taken for medical records only and will not be used for marketing without separate consent.

Area(s) to be treated \_\_\_\_\_

Product being administered today is      Rejuran I                      Rejuran Classic                      Rejuran Scar                      (circle)

The quantity to be injected today is      1mL Rejuran I                      2mL Rejuran                      4mL Rejuran                      (circle)

The cost of treatment today                      \$620                      \$1125                      \$2250                      (circle)

### Risks and Side Effects

I understand and accept the possible **common side effects and risks** associated with this treatment:

- Bruising, swelling, pain or tenderness.
- No perceived change or unexpected or undesirable cosmetic outcome.

I understand and accept the following **uncommon and rare side effects** associated with this treatment:

- Nodules, granulomas or lumps requiring medical or surgical treatment
- Allergic reaction/anaphylaxis
- Prolonged redness or sensitivity/pain at the treated sites.
- Infection and subsequent scar formation.
- Vascular occlusion leading to skin death, scarring, blindness, stroke or hair loss.
- Chemical burn resulting in scarring from the peel

### Acknowledgment of consent

- I have read and understood this consent form
- I have had enough time to discuss the treatment and ask questions
- All my questions were answered satisfactorily
- I understand my practitioner may use AI scribe to dictate my appointment
- No treatment was performed before signing this form
- I am choosing to proceed voluntarily, without pressure or coercion

*I give my full, informed consent to proceed with treatment today*

If you would like a copy of this form emailed to you, please circle      No      /      Yes      Email \_\_\_\_\_

Name of patient:      Patients signature: \_\_\_\_\_

Date: \_\_\_\_\_

Practitioner: Clinic ,      Practitioner signature: \_\_\_\_\_

Date: \_\_\_\_\_

My treating practitioner                      can be contacted on 1300 863 824 or alternatively I can email                      . In the event that I can not contact                      , I should email drgavinchan@vci.com.au or drtalhamajoka@vci.com.au should I be experiencing any problems or concerns after treatment.



## Consent for Profhilo Treatment

Patient name:

DOB:

Treating practitioner name:

Provider no.:

Treatment date:

**Treatment location:** Victorian Cosmetic Institute Level 1, 268 Manningham Road, Lower Templestowe, 3107

I, \_\_\_\_\_, have been explained the nature of the treatment, the possible risks and side effects, and the projected (but not binding) results that I may expect.

I understand that medical information can change over time, and this may change the potential benefits, risks, methodologies, and uses of Profhilo.

I also understand that the results from treatment are unique to each individual, and the outcome is inherently unpredictable. No guarantees can be made about the longevity or outcome of the treatment.

I have discussed any contraindications or relative contraindications to treatment with my practitioner, and the effect of these on my treatment.

Areas to be treated \_\_\_\_\_

Product to be administered today	Profhilo	Profhilo Structura	(circle)
Amount of product to be used	2mL	4mL	6mL (circle)
Cost of treatment	\$1125	\$2190	\$3190 (circle)

I understand and accept the side effects and risks associated with this treatment:

- Bruising
- Temporary skin discoloration
- Pain or tenderness at the treatment sites
- Swelling or oedema
- Temporary lumps
- Localised inflammation

I understand and accept the following uncommon and rare side effects associated with this treatment:

- Scarring
- Asymmetry or uneven results
- Skin necrosis at site of injection(s)
- Pigmentation changes as a result of the injections
- Allergy/anaphylaxis
- Infection
- Vascular occlusion leading to skin necrosis, scarring, blindness or stroke.

### Patient acknowledgment of consent

I certify that I have read and understood the above consent.

I understand the product, treatment process and potential benefits and risks.

I have had enough time to discuss this treatment with my practitioner and have been allowed to ask questions about the procedure.

All of my questions have been answered satisfactorily.

I understand my practitioner may use AI scribe to dictate my appointment.

I received no treatment before signing this consent form.

If you would like a copy of this form emailed to you, please circle Yes / No

Name of patient: Patients signature: \_\_\_\_\_

Date:

Practitioner: Practitioner signature: \_\_\_\_\_