MINTSKIN
AUSTRALIA

MINTSKIN clinic
Be rejuvenated Be inspired

INFORMED CONSENT FORM for Skin Booster / Micro Needling

Treatment Name _____ This blank filled out by staff ONLY

Your Detail 个人信息

Preferred name: *First Name 名 *Surname姓 :

Gender性别: **Female** Date of Birth 生日: **DD/MM/YYYY** Phone 电话号码: **+61 04**

Email 电子邮箱: **@gmail.com**

We will send you the digital version and other updates. 我们将向您发送数字版本和其他更新信息。

Emergency Contact 紧急联系人

Name紧急联系人姓名 : Phone Number 紧急联系人电话 : **+61 04**

General Health and aesthetic treatment History 健康史及医美治疗史

Have you suffered any serious illness? 您是否有任何严重病史？_____ Please fill in No if not applicable 如不适用，请填无

What operations have you had? 您做过什么手术？_____ Please fill in No if not applicable 如不适用，请填无

Please indicate if you have a history of the following: 请说明您是否有以下历史记录：

- ☐ Allergies过敏
- ☐ Rheumatic fever风湿
- ☐ Blood clots, thrombosis 血块血栓
- ☐ Heart trouble心脏疾病
- ☐ Other其他_____
- ☐ Blood pressure血压问题
- ☐ Fainting昏厥
- ☐ Epilepsy癫痫
- ☐ Kidney disease肾病
- ☐ Hepatitis肝炎
- ☐ **Bleeding tendency**出血倾
- ☐ Diabetes糖尿病
- ☐ Lung disease肺部疾病

***Bleeding tendency: Are you subject to prolonged bleeding or frequent nose bleeds?** 您是否会长期出血或频繁流鼻血？

YES是 ◯ NO否 ◯ (Please select one 必填单选)

*Are you at risk of developing HIV, AIDS or Hepatitis? 您是否有感染艾滋病毒、艾滋病或肝炎的风险？

YES是 ◯ NO否 ◯ (Please select one 必填单选)

*Have you received any aesthetic treatment within 30 day(including laser, M22,IPL, HIFU……)？Have you received any Filler? Please list 请列出你30天内接受的医美治疗（包括但不限于激光/IPL/M22/HIFU），请列出您接受过的填充项目：

_____

*Allergies: Are you allergic to any medicines, lotions or tape? Please list 请列出任何您过敏的药物、乳液或胶带：

_____

Cortisone: Have you ever been given cortisone or steroid tablets or injections? Please specify when 你是否曾服用可的松或类固醇药片或注射？请说明何时：

_____

Medication: Please list any current medication (including herbal / alternative) 请列出任何当前药物（包括草药/替代品）：

_____

*Is there anything of a confidential nature you wish to discuss with my treatment provider? 是否有隐私事项需要和治疗提供者讨论？

YES是 ◯ NO否 ◯ (Please select one 必填单选)

Please read the following statements carefully and tick all the boxes 请仔细阅读下列描述并在所有方框内打勾

☐ This treatment is performed in a safe and precise manner with the use of a sterile, disposable tip that allows effective treatment to the target area. Prior to the procedure, topical anaesthetic cream is applied for patient comfort. The entire procedure is normally completed within 30-60 minutes depending on the required treatment and the anatomical site. New healthy skin appears about 2-3weeks after treatment.该治疗将以安全、精确的方式进行，使用无菌、一次性的针头，可对标区域进行有效治疗。在治疗前，会在目标区域使用局部麻醉膏。整个过程通常在30-60分钟内完成，具体取决于所需的治疗和部位。治疗后约2-3周有的健康皮

☐ I understand that reactions such as redness, oedema (swelling), pain and itching may follow treatment, as may an acne like eruption. All these reactions are linked to the procedure itself and usually resolve after a few days. I understand that lumps, abscesses and indurations- sometimes associated with redness and/or swelling have been reported after treatment in some patients. In most cases these side effects are short-term. However, in some cases, they have lasted up to two weeks. There are rare cases in the literature of discoloration at the injection point, necrosis of the glabellar area, intraocular complications and hypersensitivity after hyaluronic acid injections. 我已了解，治疗后可能会出现发红、水肿（肿胀）、疼痛和瘙痒等反应，也可能出现痤疮样的皮疹。所有这些反应都是治疗后的正常现象，通常几天后就会消失。我已了解，一些人在治疗后可能会肿块、脓肿和硬结，有时伴有红肿。在大多数情况下，这些副作用是短期的，但在某些情况下，他们持续两周左右。在极少数的文献中记录了出现注射点变色、眉间区坏死、眼内并发症和透明质酸注射后过敏的情况，但他们是极其罕见的。

Patients with a history of herpes simplex (cold sores) should note that there is a small risk that injecting product around previously affected areas may cause the herpes to flare up again. 有单纯疱疹（冻疮）病史的患者应注意，在以前受影响的区域实施治疗，可能会有很小的风险导致疱疹再次发作。

☐ I know all side effects must be reported to my treatment provider as soon as possible. 我知道如果出现上述副作用，必须尽快告知我的治疗提供者。

☐ I understand that the treatment is variable and that the outcome of the treatment cannot be guaranteed. 我知道治疗包含了多种可变因素，无法保证治疗结果。

☐ After treatment, I will follow the advice given by my practitioner to achieve satisfactory aesthetic results. I realise that if I do not follow this advice, the end result may be less optimal. 治疗后我会按照专业人士的建议，以达到更满意的效果。我了解如果我不遵循这个建议，最终的结果可能会不那么理想。

☐ I am aware of the importance of follow up care and my own responsibility. How and when the treatment should be provided, the likely benefits and possible undesirable effects have been explained to me. 我已经知道后续护理的重要性和我自己的责任。如何以及何时进行治疗，治疗的可能的好处和可能的不良影响已经向我解释过了。

☐ I have replied honestly to all questions about my medical and aesthetic history. I have been given the chance to ask all the questions I wanted and I have received satisfactory replies to all of them. Now that the procedure has been fully explained to me, I consent to have this treatment. 我诚实地回答了所有关于我的健康史和医美史的问题。我有机会问我想问的所有问题，我得到了满意的答复。治疗过程已经充分地介绍给我了，我同意接受适此项治疗。

☐ I understand that it is not advisable to have this treatment for a week either side of a COVID-19 vaccination. 我知道在接种2019冠状病毒疫苗的前后一周内都不能进行此项治疗。

☐ **I am NOT in a lactation period or pregnant period.** 本人未处于哺乳期或者怀孕期

☐ I confirm my skin and other health conditions are suitable for this treatment. 我确认本人皮肤和其他健康状况适合操作此项目。

☐ I know the repeated treatment by month will help to achieve a better result and results can vary by each customer. 本人已知晓该项目按月度疗程治疗更有助于呈现好的结果，效果将因人而异。

Post Care instructions 治疗后护理建议

- Avoid prolonged sun exposure, high temperature yoga and sauna and other activities at high temperature. 应避免长时间日光暴晒，高温瑜伽和桑拿等高温活动。
- Avoid bacterial infection at the treatment site . Use physical and chemical methods to prevent UV and you need to wear at least a SPF 30 sunscreen. Pay more attention to skin moisturizing between treatments. 避免治疗部位受到细菌感染。使用物理和化学方法防晒，并使用至少SPF 30的防晒霜。在治疗后以及治疗间隔期做好肌肤保湿。
- Avoid using irritating cosmetics such as whitening, and exfoliate and peel treatments must be under the guidance of professionals. 应避免使用美白等刺激性化妆品，在专业人员指导下进行去角质和刷酸。
- DO NOT drink and smoke.禁止抽烟，喝酒

Signed签名 _____ Date 日期 _____ (DD/MM/YYYY)

Privacy Consent Form 隐私同意书

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.我们要求您同意收集您的个人信息。请仔细阅读此信息，并在下面指示的位置签名。

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways: 本医疗机构从您处收集信息的主要目的是提供优质医疗服务。我们要求您向我们提供您的个人详细信息和完整的病史，以便我们能够正确评估、诊断、治疗您的健康护理需求，并采取积极主动的态度。这意味着我们将通过以下方式使用您提供的信息：

- Administrative purposes in running our clinics, including confirmation of appointments,take before and after photographs of you, write file notes about your skin, your treatment, medical conditions and your leisure activities. 管理我们诊所的目的，包括预约确认, 拍摄你的前后照片，记录你的皮肤、治疗、医疗状况和日常活动。‹
- Billing purposes 计费目的。
- Disclosure to others involved in your health care, including treating doctors and specialists outside our clinics. This may occur through referral to other doctors, or for medical tests, and in the reports or results returned to us following the referrals. 向参与您医疗保健的其他人披露，包括在本医疗机构之外治疗医生和专家。这可能通过转诊给其他医生或进行医学测试，以及在转诊后返回给我们的报告或结果。
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care, teaching and research. Please let us know if you do not want your records accessed for these purposes and we will note your record accordingly. 为患者护理、教学和研究的目的，向执业机构的其他医生、医生和注册人员披露信息。如果您不希望出于这些目的访问您的记录，请告知我们，我们将相应地记录您的记录。

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.我已阅读上述信息，并理解必须收集我的信息的原因。我还知道，该机构在处理患者信息方面有隐私政策。

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.我理解，我没有义务提供要求我提供的任何信息，但如果我不这样做，可能会影响提供给我的医疗保健和治疗的质量。

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.我知道我有权访问收集到的关于我的信息，除非在某些情况下，可能会合法地拒绝访问。我知道在这种情况下我会得到解释。

I consent to the use of my non-identifying clinical photographs for educational purposes in the practice / at medical lectures / medical journals, or for marketing purposes我同意将我的非识别临床照片用于实践/医学讲座/医学期刊的教育目的，或用于营销目的。.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.我理解，如果我的信息用于上述以外的任何目的，我将获得进一步的同意。

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.本人同意本机构出于上述目的处理本人的信息，但须遵守本人通知本机构的任何访问或披露限制。

Signed签名 _____ Date 日期 _____ (DD/MM/YYYY) Witness 见证人_____