CoolSculpting Consent Form

Cryolipolysis Body Contouring Treatment

Pabau

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____ **Phone Number:** _____

Email Address: _____

Address: _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

TREATMENT DESCRIPTION

CoolSculpting (cryolipolysis) is a non-invasive body contouring procedure that uses controlled cooling to eliminate stubborn fat cells. The treated fat cells are crystallised (frozen) and then naturally processed and eliminated by the body over time. CoolSculpting is **not a weight-loss treatment** and is intended for localised fat reduction only.

Treatment areas may include the abdomen, flanks (love handles), inner and outer thighs, upper arms, bra fat, back fat, underneath the buttocks (banana roll), and submental area (double chin). Results typically become visible within 1 to 3 months, with full results appearing after approximately 2 to 4 months.

TREATMENT AREAS (CHECK ALL THAT APPLY)

- ☐ Abdomen
- ☐ Flanks (Love Handles)
- ☐ Inner Thighs
- ☐ Outer Thighs
- ☐ Upper Arms
- ☐ Bra Fat
- ☐ Back Fat
- ☐ Banana Roll (Under Buttocks)
- ☐ Submental (Double Chin)
- ☐ Other: _____

MEDICAL HISTORY & CONTRAINDICATIONS

Absolute Contraindications

- ☐ Yes ☐ No Do you have cryoglobulinaemia?
- ☐ Yes ☐ No Do you have cold agglutinin disease?
- ☐ Yes ☐ No Do you have paroxysmal cold haemoglobinuria?
- ☐ Yes ☐ No Do you have Raynaud's disease?
- ☐ Yes ☐ No Do you have any known cold-sensitivity disorders?

Relative Contraindications & Medical History

- ☐ Yes ☐ No Are you currently pregnant or breastfeeding?
- ☐ Yes ☐ No Do you have a hernia in or near the treatment area?
- ☐ Yes ☐ No Do you have any skin conditions in the treatment area (eczema, dermatitis, rashes)?
- ☐ Yes ☐ No Do you have impaired peripheral circulation?
- ☐ Yes ☐ No Do you have neuropathic conditions (e.g. diabetic neuropathy, post-herpetic neuralgia)?
- ☐ Yes ☐ No Have you had recent surgery in the treatment area?
- ☐ Yes ☐ No Do you have any implanted medical devices (pacemaker, defibrillator) near the treatment area?
- ☐ Yes ☐ No Are you currently taking blood-thinning medications (anticoagulants)?
- ☐ Yes ☐ No Do you have a history of paradoxical adipose hyperplasia (PAH)?
- ☐ Yes ☐ No Do you have any allergies to isopropyl alcohol, propylene glycol, or similar substances?

RISKS, SIDE EFFECTS & COMPLICATIONS

Common side effects include temporary redness, swelling, bruising, firmness, tingling, stinging, tenderness, cramping, aching, itching, and skin sensitivity at the treatment site. These typically resolve within days to weeks.

Less common side effects may include late-onset pain (beginning several days after treatment), persistent numbness or altered sensation, and hyperpigmentation or hypopigmentation of the treated area.

Rare complications include paradoxical adipose hyperplasia (PAH), which is an enlargement of the treated area rather than reduction. PAH may require additional treatment, including liposuction, to correct. Frostbite, scarring, and changes in fat distribution are rare but possible.

Alternatives to CoolSculpting include liposuction, laser lipolysis, radiofrequency treatments, injectable fat-dissolving agents, and lifestyle changes (diet and exercise).

CONSENT ACKNOWLEDGEMENTS

(initial each acknowledgement line below)

1. I confirm that I have read and understood the information provided about the CoolSculpting procedure, including the risks, benefits, and alternatives. _____
2. I confirm that I have had the opportunity to ask questions and that all my questions have been answered to my satisfaction. _____
3. I understand that CoolSculpting is not a weight-loss treatment and that results may vary from person to person. _____
4. I understand the risk of paradoxical adipose hyperplasia (PAH) and that additional corrective treatment may be required. _____
5. I confirm that the medical history information I have provided is accurate and complete to the best of my knowledge. _____
6. I consent to before-and-after photographs being taken for my medical records. _____
7. I understand that I may withdraw my consent at any time before the procedure begins. _____
8. I voluntarily consent to the CoolSculpting treatment and accept responsibility for the risks outlined above. _____

PHOTOGRAPHY CONSENT (OPTIONAL)

☐ Yes ☐ No I consent to my photographs being used for educational or training purposes (anonymised).

☐ Yes ☐ No I consent to my photographs being used for marketing or social media purposes (anonymised).

SIGNATURES

Patient / Client Signature _____ Date _____

Practitioner / Provider Signature _____ Date _____

Witness (if applicable) Signature _____ Date _____