

FUE Hair Transplant

Status: active Form type: default Company: Acme Inc

PROCEDURE OVERVIEW

Follicular Unit Extraction (FUE) is a hair restoration technique involving the individual removal of hair follicles from a donor area (usually the back or sides of the scalp) and their implantation into areas experiencing thinning or baldness. This minimally invasive procedure avoids linear scarring and offers natural-looking results.

POTENTIAL RISKS AND COMPLICATIONS

I understand that, as with any medical procedure, FUE carries certain risks, including but not limited to: Swelling, bruising, and redness at donor or recipient sites Infection Folliculitis (inflammation of hair follicles) Scarring, including possible keloid formation (especially in those prone) Itching or temporary numbness Poor or delayed hair growth in transplanted area Cyst formation Shock loss (temporary hair shedding post-procedure) Asymmetry or uneven hair density The need for additional procedures to achieve the desired result All potential risks and complications have been explained to me in detail.

PRE-TREATMENT CONSIDERATIONS

I confirm that I have disclosed my full medical history, including any medications, allergies, or pre-existing conditions. I understand that smoking, alcohol, and certain medications may affect the success and healing of the transplant. I understand that results vary and may take 6–12 months to become fully visible. There is no guarantee of the exact density, coverage, or growth success.

AFTERCARE INSTRUCTIONS

Avoid touching, scratching, or rubbing the transplant area for at least 7–10 days Sleep with your head elevated for the first few nights to reduce swelling Do not wash your hair for the first 48 hours, then follow the clinic's specific shampooing instructions Avoid direct sun exposure, strenuous activity, swimming, and saunas for at least 2 weeks Do not wear hats, helmets, or tight headwear until advised by your practitioner Take any prescribed antibiotics, painkillers, or anti-inflammatory medication as directed Attend all follow-up appointments to monitor progress and healing

INFORMED CONSENT AND PHOTOGRAPHY

I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: the aims/motivations for having the procedure and the desired outcome the risks inherent in the procedure the risks inherent in refusing the procedure the risks specific to me the expected benefits of the treatment the potential disadvantages of the treatment alternative procedures and their pros and cons – including the option of no treatment at all any uncertainties about and the likelihood of success of the procedure any follow-up treatment that may be required Clinical Photographs and Videos: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records.

I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

Yes No

Do you feel sufficient information has been provided to you, to enable you to consent?

Yes No

Has your consent been freely given?

Yes No

Do you have any medical conditions?

Yes No

Are you pregnant or breastfeeding?

Yes No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

Do you have an autoimmune disease?

Yes No

Do you have any skin conditions?

Yes No

Do you have any known allergies or have ever had anaphylaxis?

Yes No

Do you have any active infection at the intended site of procedure?

Yes No

Are you taking antibiotics or other prescription medications?

Yes No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.