Hair Transplant Consent Form

Pabau

PATIENT INFORMATION

Patient Full Name: _____

Date of Birth: _____ **Gender:** _____

Contact Phone Number: _____

Email Address: _____

Residential Address: _____

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

Primary Care Physician: _____

Referring Doctor (if applicable): _____

PROCEDURE DETAILS

Please select the technique and areas to be treated:

TREATMENT SPECIFICATIONS

Estimated Number of Grafts: _____ **Number of Sessions Planned:** _____

Donor Area(s): _____ **Recipient Area(s):** _____

ABSOLUTE CONTRAINDICATIONS

Please answer YES or NO to each question. Any YES answer requires specialist clearance before proceeding.

☐ Yes ☐ No Do you have any active scalp infections or inflammatory conditions?

☐ Yes ☐ No Have you been diagnosed with psoriasis, eczema, or seborrheic dermatitis affecting your scalp?

☐ Yes ☐ No Do you have a history of keloid or hypertrophic scar formation?

☐ Yes ☐ No Do you have alopecia areata or other non-pattern hair loss conditions?

☐ Yes ☐ No Do you have any bleeding disorders (e.g., haemophilia, von Willebrand disease)?

☐ Yes ☐ No Are you required to take blood-thinning medications that cannot be safely discontinued?

☐ Yes ☐ No Have you experienced excessive bleeding during previous surgeries or dental procedures?

☐ Yes ☐ No Do you have unstable cardiac disease or uncontrolled hypertension?

☐ Yes ☐ No Do you have active or recent respiratory disease requiring medical management?

☐ Yes ☐ No Are you currently undergoing chemotherapy or radiation therapy?

☐ Yes ☐ No Are you taking immunosuppressive medications (e.g., for organ transplant)?

☐ Yes ☐ No Do you have uncontrolled diabetes with HbA1c >8%?

☐ Yes ☐ No Have you been diagnosed with body dysmorphic disorder (BDD)?

☐ Yes ☐ No Do you have unrealistic expectations about hair transplant outcomes?

☐ Yes ☐ No Are you under 21 years of age with limited hair loss?

☐ Yes ☐ No Are you experiencing significant stress or mental health concerns currently?

RELATIVE CONTRAINDICATIONS

These conditions may affect your candidacy or require modification of the treatment plan:

☐ Yes ☐ No Do you currently smoke cigarettes or use tobacco products?

☐ Yes ☐ No Do you consume alcohol regularly (more than 7 drinks per week)?

☐ Yes ☐ No Are you willing to abstain from smoking for at least 2 weeks before and after surgery?

☐ Yes ☐ No Are you currently taking aspirin, NSAIDs, or other blood thinners?

☐ Yes ☐ No Are you taking herbal supplements that may affect bleeding (ginkgo, garlic, ginseng)?

☐ Yes ☐ No Have you used isotretinoin (Accutane) in the past 12 months?

☐ Yes ☐ No Are you currently using finasteride or dutasteride for hair loss?

☐ Yes ☐ No Have you had previous hair transplant procedures?

☐ Yes ☐ No Were you satisfied with the results of previous hair transplants?

☐ Yes ☐ No Have you had scalp reduction or flap procedures?

☐ Yes ☐ No Have you undergone scalp micropigmentation (SMP)?

☐ Yes ☐ No Is there significant miniaturisation in your donor area?

☐ Yes ☐ No Do you have sufficient donor hair density for the planned procedure?

☐ Yes ☐ No Have you experienced rapid hair loss progression in the past year?

PROCEDURE UNDERSTANDING AND ACKNOWLEDGEMENTS

Please initial each statement to confirm your understanding:

(initial each acknowledgement line below)

1. I understand that hair transplantation redistributes existing hair and does not create new hair follicles. _____
2. I understand that the density achieved will not match my pre-baldness hair density. _____
3. I acknowledge that pattern hair loss is progressive and I may require future procedures. _____
4. I understand that final results will not be visible for 10-12 months after surgery. _____
5. I acknowledge that shock loss (temporary shedding of existing hair) may occur in the recipient area. _____
6. I understand that graft survival rates are typically 90-95% but cannot be guaranteed to be 100%. _____
7. I acknowledge that I may need to use finasteride or minoxidil long-term to maintain non-transplanted hair. _____
8. I understand that donor area scarring will occur (linear scar for FUT, dot scars for FUE). _____
9. I acknowledge that the final graft number may vary from the estimate based on donor assessment during surgery. _____

RISKS AND COMPLICATIONS ACKNOWLEDGEMENT

I understand the following potential risks and complications:

(initial each acknowledgement line below)

1. Temporary swelling of the forehead and around the eyes lasting 2-5 days. _____
2. Crusting at graft sites that will resolve within 5-10 days. _____
3. Temporary numbness in donor or recipient areas that may persist for weeks to months. _____
4. Infection requiring antibiotic treatment (rare with proper post-operative care). _____
5. Bleeding, haematoma formation, or excessive oozing from graft sites. _____
6. Poor graft survival resulting in patchy growth or low density. _____
7. Unnatural hairline appearance requiring revision surgery. _____
8. Asymmetry or irregular density distribution. _____
9. Donor area scarring that may be visible with very short haircuts. _____
10. Cyst formation, folliculitis, or ingrown hairs at recipient sites. _____
11. Keloid or hypertrophic scarring in predisposed individuals. _____
12. Allergic reactions to anaesthesia, antibiotics, or topical medications. _____
13. Unsatisfactory aesthetic result requiring additional procedures. _____
14. Permanent loss of sensation in donor or recipient areas (very rare). _____

PRE-OPERATIVE INSTRUCTIONS ACKNOWLEDGEMENT

I agree to follow these pre-operative instructions:

(initial each acknowledgement line below)

1. Discontinue aspirin, NSAIDs, and blood-thinning supplements 7-10 days before surgery. _____
2. Stop smoking at least 2 weeks before and after the procedure. _____
3. Avoid alcohol for 48 hours before surgery. _____
4. Wash hair thoroughly on the morning of the procedure. _____
5. Arrange transportation to and from the clinic (I will not drive after sedation). _____

6. Wear comfortable, button-front clothing on the day of surgery. _____

7. Inform the clinic immediately if I develop any illness or infection before the scheduled date. _____

8. Complete any required pre-operative blood tests or medical clearances. _____

POST-OPERATIVE CARE INSTRUCTIONS ACKNOWLEDGEMENT

I agree to follow these post-operative care instructions:

(initial each acknowledgement line below)

1. Sleep with my head elevated at 45 degrees for 5 nights after surgery. _____
2. Avoid touching, rubbing, or scratching the grafts for 10 days. _____
3. Refrain from strenuous exercise or heavy lifting for 2 weeks. _____
4. Avoid direct sun exposure to the scalp for 3 weeks. _____
5. Begin gentle shampooing on days 3-5 following specific instructions provided. _____
6. Take all prescribed medications (antibiotics, pain relief, anti-inflammatory) as directed. _____
7. Avoid alcohol consumption for 5 days after the procedure. _____
8. Refrain from swimming, saunas, or steam rooms for 3 weeks. _____
9. Attend all scheduled follow-up appointments (1 week, 1 month, 3 months, 6 months, 12 months). _____
10. Contact the clinic immediately if I experience signs of infection, excessive bleeding, or severe pain. _____

ALTERNATIVE TREATMENT OPTIONS DISCUSSED

The following alternative treatments were discussed with me:

Medical Management (finasteride, minoxidil, PRP):

_____

_____

Scalp Micropigmentation (SMP):

_____

_____

Hair Systems / Wigs:

_____

_____

Low-Level Light Therapy (LLLT):

_____

_____

Other Options or My Decision to Proceed:

_____

_____

_____

FINANCIAL AGREEMENT

Total Procedure Cost (Currency): _____

Deposit Amount Paid: _____ **Balance Due:** _____

Payment Method: _____ **Cancellation Policy Acknowledged:** _____

> **Patient Declaration:** I acknowledge that I have read this consent form and understood all the information provided. I have been given adequate opportunity to ask questions, and my questions have been answered to my satisfaction. The risks, benefits, limitations, and alternative treatments have been explained to me. I understand that no guarantees have been made regarding the outcome of this procedure. I voluntarily choose to proceed with hair transplantation.

CONSENT SIGNATURES

Client Signature _____ Date _____

Client Signature _____ Date _____

Client Signature _____ Date _____

For Clinic Use Only:

Date consent form provided to patient: _____

Date patient returned for questions: _____

Pre-operative checklist completed: ☐ Yes

Medical clearances obtained: ☐ Yes ☐ N/A

Photography consent signed: ☐ Yes ☐ No

Financial agreement signed: ☐ Yes