

~ LOGO ~

BASIC CLIENT INFORMATION

Client's Name & Surname	
Date of Birth and Age	
Proof of age (ID/Passport)	
Address	
Contact number	

HEALTH STATUS

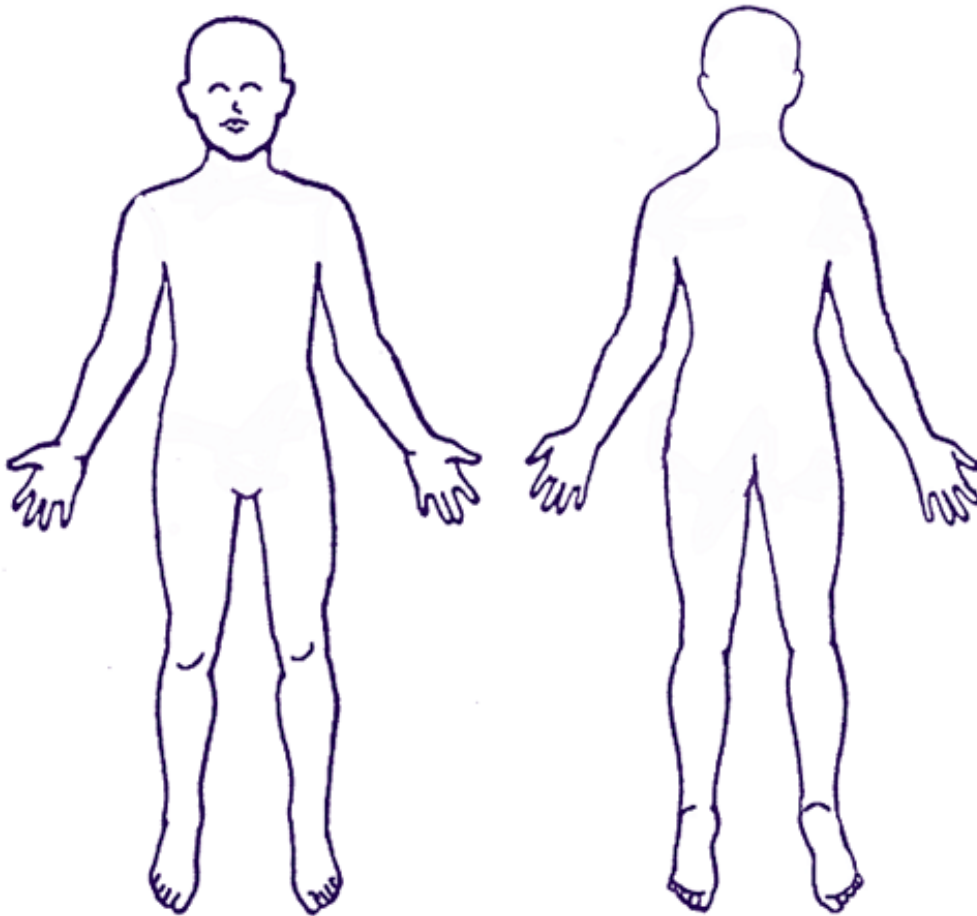
	Y	N
Do you suffer from Diabetes?		
Do you suffer from infectious diseases such as Tuberculosis or Herpes?		
Do you suffer from Hepatitis, HIV, AIDS or other blood-borne infection?		
Do you suffer from any skin condition?		
Do you suffer from epilepsy / seizures?		
Do you suffer from haemophilia?		
Do you have any heart condition?		
Are you pregnant or lactating?		
Do you suffer from fainting or dizziness?		
Do you have any relevant allergies (latex, metals)?		
Do you take medicines that thin blood?		
Are you on any steroid therapy?		
Are you on chemotherapy or radiotherapy?		
Did you drink any alcohol during the past 24 hours?		
Did you take any drugs of abuse / mind altering drugs during the past 24 hours?		

If the client has a condition listed under health status, the client needs to submit a doctor's certificate to certify that the client is fit to have a procedure in a specific body part.

THE PROCEDURE

Full name of operator	
Date of procedure	
Type of procedure	
Part of body where procedure will be carried out	
Description of procedure	

Indicate all above on a body sketch



CLIENT'S CONSENT (to be signed BEFORE the procedure)

I, _____, I.D. _____ hereby request and consent to the above treatment/procedure to be carried out on my body. I declare that I am of adult consenting age (18 years or older). I do not suffer from any medical condition listed under health status that may interfere in, or in any way complicate the procedure that will be carried out on my body or the healing phase (see doctor's note). I give the practitioner permission to perform, necessary examinations and assessments, as well as diagnostic procedures as may be deemed necessary, in order to provide me with the best quality care.

I understand that all of my personal information is confidential and will be used for no other purpose than for the practitioner's clinical records. I understand that, as in all health care procedures, there are some very slight risks to treatment, which are not limited to pain, swelling and infection. I have read the above consent and I have had the opportunity to ask questions about its content, and by signing below I agree to the treatment performed by the practitioner.

I understand that the personal data about me in this consent form/client's record will be kept in accordance with the current Data Protection Legislation, and can be seen and reviewed by any health professional in the interest of Public Health.

Full name of client _____ Signature of client _____

Full name of operator _____ Signature of operator _____

Date _____

Aftercare (to be signed AFTER the procedure)

I declare that I have been given the aftercare information both verbally and in writing.

Signature of client _____