

Sedation - Local Anaesthetic Consent Form

The re-distribution of your hair is performed under a local anaesthetic and/or where indicated sedation anaesthetic. In order to assist us and in the interest of your own safety, please answer the following questions fully.

Have you ever suffered or suffer from any of the following:

Heart problems yes no

Blood circulation yes no

Lung disease yes no

Liver disease yes no

Gastric disorders yes no

Intestinal complaints yes no

Kidney or urinary disease yes no

Do you suffer from diabetes or any other related illness? yes no

Haemophilia yes no

Allergies yes no

If yes, please give details

_____ yes no

Do you suffer a chronic infection illness? (AIDS, Hepatitis, Tuberculosis, etc.) yes no

Do you suffer from any other illnesses not described above? yes no

If yes, please give details

Do you use any medications? yes no

If yes, please give details

_____ yes no

Do you smoke? yes no

If yes, how many cigarettes a day?

Do you use drugs, XTC, etc.? yes no

Have you ever suffered from adverse reactions following a local anaesthetic e.g., dentist? yes no

I have not consumed alcohol or used a painkiller during the last 4 days. yes no

Have you had a previous hair transplantation? yes no

If so:

Where _____

When _____

By whom _____

I confirm that I have been fully informed about the local anaesthetic. I understand that I will be administered a local anaesthetic for this treatment and I agree to this procedure. I declare that the information given above is correct.

Note: After a local anaesthetic it is advised not to drive for at least 12 hours or until you have fully recuperated. The use of alcohol should be avoided for a minimum period of 2/3 days.

Special notes: _____

Patient's signature _____ Date and Location: _____

Performing Surgeon's signature _____ Date and Location: _____