



3D NIPPLE AREOLA TATTOO CLIENT HISTORY AND CONSENT FORM

NAME.....DATE.....

ADDRESS.....

PHONE.....EMAIL.....

SURGEONS NAME.....

SURGEONS ADDRESS.....

SURGEONS PHONE NUMBER.....

ARE YOU CURRENTLY ON ANY MEDICATION?

- NO
- YES- PLEASE LIST BELOW

.....

.....

.....

HEALTH CONCERNS- PLEASE TICK

- DIABETES
- PACE MAKER
- PREGNANT
- AIDS
- HEPATITIS A, B OR C
- KELOID SCARS
- HAEMOPHILIA
- EPILEPSY
- OTHER- PLEASE LIST

.....

.....

DATE OF FIRST SURGERY.....DATE OF LAST SURGERY.....

SURGERY DETAILS- PLEASE TICK

- BILATERAL MASTECTOMY
- UNILATERAL MASTECTOMY
 - LEFT
 - RIGHT
- CHEMOTHERAPY
 - RADIATION
 - OTHER

.....
.....

- MASTOPLEXY
 - TISSUE
- RECONSTRUCTION WITH IMPLANTS
-

AUTOLOGOUS RECONSTRUCTION - PLEASE TICK

- DIEP (ABDOMINAL)
- TRAM (ABDOMINAL INC MUSCLE)
- GLUTEAL (BUTTOCKS)
- TMG (THIGH)
- AUTOLOGOUS WITH IMPLANT RECONSTRUCTION
- OTHER

.....
.....

NIPPLE RECONSTRUCTION

LOCAL TISSUE

SKIN GRAFT- PLEASE INDICATE DONOR SITE

.....
.....
.....
.....
.....
.....

CONSENT

**I understand that topical anaesthetics used may contain Lignocaine and Tetracaine
I have been given the opportunity to discuss shape and colour for this procedure and I am happy with both choices
I understand that this treatment is for cosmetic purposes only
I understand that no guarantees have been made to me regarding the results
I am responsible for the at home care which may have risk of infection
I will not hold the therapist responsible in the event of any damage and shall not be entitled to take action against her at law or in equity for such treatment
I consent to before and after photographs of this procedure which is at the therapists discretion
I cannot donate blood for 6 months from today
I have had the opportunity to ask questions relating to this treatment**

CLIENT SIGNATURE (PRE PROCEDURE)

.....DATE.....

OFFICE USE ONLY

NOTES

.....
.....
.....
.....

