

Business name _____

Electrolysis Consent

This treatment uses a fine needle and a small electrical current, so the main risks are a small chance of scarring or pigment change if an area is overtreated, and interference with pacemakers or similar implants. That's what the questions below are checking for.

Full name _____

Date of birth _____

Home address _____

Emergency contact (name and relationship) _____

GP name (so we can follow up if needed) _____

Do you smoke? ☐ Yes ☐ No

Do you have a pacemaker or any other electronic medical implant? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have diabetes, epilepsy, or a history of keloid scarring? ☐ Yes ☐ No

Are you taking blood-thinning medication? ☐ Yes ☐ No

☐ I understand the aftercare advice given and agree to follow it.

☐ I confirm the information I've given above is accurate, and I consent to this treatment.

☐ I give my explicit consent for the business named above to use the health information on this form to provide my treatment safely.

Client's signature _____ Date _____

Client's name in capitals _____

Therapist's signature _____ Date _____