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 _____