Shining Way Esthetics

Consent for Treatment

Vampire Facelift / PRP (Platelet Rich Plasma)

A. Purpose

Using blood-derived growth factors (platelet rich fibrin matrix [PRFM]), Platelet Rich Plasma (PRP), also known as the Vampire Facelift™ is a safe procedure for renewing the skin of the face and for correcting shape.

B. Benefits

This treatment is natural in that your own cells are used, treated with a chemical that is not foreign to the body, and injected into the specified areas. Since a distillate of growth factors from your own blood (PRFM) is used, there should be no side effects from the material injected. The body reacts to the treated cells as it does to a wound and immediately starts repairing the tissue. This builds the underlying tissue with tightening, smoothing, and increased blood flow (which makes the color more attractive). You should see improvements immediately, although there is usually a return to prior treatment status in 3-5 days as the water is absorbed and prior to the complete action of the cellular regenerative process. Within 2-4 weeks you will see improvement with continued changes for 12 weeks.

There's actual growth of new tissue by stimulation of uni-potent stem cells, so the change is not from something foreign being in the body but from the body actually rejuvenating and growing. The PRFM stimulates new blood flow with new blood vessels (neovascularization).

The results of this treatment should and can last, but results may vary and research documenting the longevity or results are ongoing.

C. Treatment

You may take a pain medication, such as Tylenol™ or a prescription medication may be requested. You may ask for an anti-anxiety medication to use prior to the treatment.

A numbing cream (lidocaine, bupivacaine, or tetracaine) is applied to the face or other treatment areas.

Approximately 10cc (less than 2 tablespoons) of blood are drawn in the same way blood samples are taken for routine lab tests.

The tubes of blood are centrifuged to separate the component cells. Platelets are separated and used for this procedure.

The platelets are treated with calcium chloride which acts as an activator for the plasma cells. The platelets release growth factors into the liquid of the tube.

The liquid is transferred into a syringe and injected into the face using a tiny needle and a process is used to distribute the growth factors and increase their effectiveness.

D. Foreseeable risks and Discomforts
The primary risks and discomforts are related to the blood draw where there is a slight pinch to insert the needle for collection and there is a potential for bruising at the site. The injections at the treatment locations cause pain similar to an intramuscular injection (since a small needle and numbing cream are used).

There is a potential for bruising at the injection sites. Pain from bruising could occur.

Smokers have less positive response to this treatment than non-smokers, since the toxins in tobacco smoke block the response of the stem cells.

There may be some variation in achieving the results requested as everyone's body type is different and may have a different response.

The introduction of the needle into the skin always presents the possibility of infection, scarring, loss of sensation, or change in muscle strength. A difference in size of the face on one side compared to the other could occur.

E. Post-Treatment
The post treatment therapy has been explained at the time of injection and I acknowledge that written instructions were given and are understood.

F. Follow-Up
Dr. De Souza will follow up with you to check on your progress and answer any questions. You may call him to report on your progress or ask questions. He can be reached at 281-813-8866 or 713-410-8692.

G. Privacy
Your privacy is protected as described in our office Privacy Act Document.

PHOTOGRAPHS
I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand that my identity will be protected.

H. Payment
I understand that this is a cosmetic procedure and that payment is my responsibility. Payment in full is required at the time of service and is non-refundable. I also understand that the cost of additional treatments, including enhancements, in order to help me achieve my desired goals, will be my financial responsibility.

I have read the above document and understand it.

If this procedure involves the use of other materials, a separate and additional consent form may be used.

The practitioner and staff have answered all my questions satisfactorily.

I accept the risks and complications of this procedure.

Patient Signature: _____ Date: _____

Printed Name: _____

Practitioner Signature: _____ Date: _____

Printed Name: _____