

miraDRY TREATMENT CONSENT FORM

miraDRY is a non-surgical treatment designed to permanently reduce underarm sweat, odor, and hair with as little as one treatment, in one hour, and with immediate results. **Initial:** _____

Clinical studies have demonstrated an average reduction of 82% in underarm sweat, 89% reduction in odor and 70% reduction in hair growth. Like any other medical procedure, results can vary from patient-to-patient. **Initial:** _____

WHAT YOU CAN EXPECT

SIDE EFFECTS AND RISKS:

- Due to the anesthesia, you may experience bruising at the injection site. You may also experience shaking, numbness or tingling in the arm, lasting about 24 hours.
Initial: _____
- After the treatment, you may experience swelling, redness, temporary altered sensation, tingling, soreness, weakness, tight banding, pain, or bumps under the skin in the treated area and/or upper arm. In most cases, these side effects will gradually go away. In rare cases, it can last for several months.
Initial: _____
- Discomfort, tenderness, or pain in the underarm is typically treatable with non-prescription medications such as ibuprofen. In rare cases, prescription medications may be needed. **Initial:** _____
- In rare situations, hyperpigmentation (darkening of the skin), burns, skin infections, rashes, and altered sweating in other areas of the body may occur. **Initial:** _____

RESULTS:

- Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure. **Initial:** _____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

- Heart pacemaker and other electronic implants.....YES/NO
- In need of supplemental oxygen.....YES/NO
- Known history of intolerance of local anesthesia, including lidocaine and epinephrine.....YES/NO
- Pregnancy.....YES/NO
- Underlying skin conditions.....YES/NO
- Previous axillary surgery.....YES/NO

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I give my consent to be treated with the miraDRY procedure by the physician(s) in this practice and his/her designated staff.

Print Name: _____ Signature: _____ Date: _____

Witness: _____ Signature: _____ Date: _____

Physician: _____ Practice name: **DEFATTA FACIAL PLASTICS**