Patient Consent Form

AN ULTHERAPY TREATMENT SHOULD ONLY BE PERFORMED AFTER A COMPLETE DISCUSSION OF THE RISKS RELATED TO THE TREATMENT AND WRITTEN INFORMED CONSENT OBTAINED.

PATIENT CONSENT

The following points of information have been specifically discussed and I have had the opportunity to ask any questions concerning this information:

- The Ulthera® System delivers a low amount of focused ultrasound energy to the skin. The heat from the ultrasound stimulates new collagen to form**.** I understand that there can be discomfort during the treatment when the ultrasound energy is delivered. I have discussed with my practitioner the options available to me to optimize my comfort during the procedure.

  Initial_____

- Immediately following Ultherapy®, the skin may appear red for a few hours. It is not uncommon to experience slight swelling for a few days following the procedure or tingling/tenderness to the touch for days to weeks following the procedure, but these are mild and temporary in nature.

  Initial_____

- Occasional temporary effects may include bruising or welts, which resolve in hours to days, or numbness in a select area, which resolves in days to weeks.

  Initial_____

- As with any medical procedure, there are possible risks associated with the treatment. There is a remote risk of a burn that may or may not lead to scarring (either of which will respond to medical care), or temporary nerve inflammation, which will resolve in a matter of days to weeks. Temporary local muscle weakness may result after treatment due to inflammation of a motor nerve. Temporary numbness may result after treatment due to inflammation of a sensory nerve.

  Initial_____

- It has been explained to me that the results vary from patient to patient, and, occasionally, the collagen building on the inside that helps counter the effects of gravity does not have a visible effect on the outside. I understand that results will unfold over the course of 3 to 6 months and that some patients may benefit from more than one treatment. I also understand that a non-invasive Ultherapy treatment is not intended to produce the same results as an invasive surgical procedure.

  Initial_____

I now authorize _____ to begin my Ultherapy treatment.

Patient _____

Address_____

_____

Telephone_____

ULTHERA EMPLOYEE STATEMENT: I have fully explained to the patient, _____, the nature and purpose of the Ultherapy treatment and the potential risks associated with that treatment. I have asked the patient if he/she has any questions regarding this treatment or the risks and have answered those questions to the best of my ability. I also acknowledge that I have read and understand the prescribing information listed above.

_____

Ulthera Employee Date

1000654FRM RevA

Ultherapy® Consult Record

Patient Name: Date:

Medical and Surgical History

Age: ____Weight: ____lbs. Height:____ Gender: ☐ M ☐ F

Active Severe or Cystic Facial Acne*	☐YES	☐NO	Mechanical or other implants in the treatment area**	☐YES	☐NO
Open facial wound or lesion*	☐YES	☐NO	Active or local skin disease that may alter wound healing***	☐YES	☐NO
Metal stents in the treatment area**	☐YES	☐NO	Autoimmune Disease***	☐YES	☐NO
Implanted electrical devices**	☐YES	☐NO	Epilepsy***	☐YES	☐NO
Pregnant or lactating***	☐YES	☐NO	Herpes or Cold sores***	☐YES	☐NO
Migraines***	☐YES	☐NO	Diabetes***	☐YES	☐NO
Bell's palsy***	☐YES	☐NO			
Hemorrhagic or bleeding disorders***	☐YES	☐NO			

List any chronic illness:

_____

Undergone the following cosmetic procedures in the brow or lower face and neck area:

Facial skin tightening procedure treatment within the last 1 year..... ☐YES ☐NO
Treatment name: _____ Location treated: _____ Date of last treatment _____
Filler (i.e. Juvederm® or Sculptra®) within the last 3-6 months..... ☐YES ☐NO
Product name:_____ Location treated: _____ Date of last treatment _____
Neurotoxin (i.e. Botox® or Dysport®) within the last 3-6 months..... ☐YES ☐NO
Product name:_____ Location treated: _____ Date of last treatment _____
Ablative resurfacing laser treatment ..... ☐YES ☐NO
Treatment name:_____ Location treated:_____ Date of last treatment _____
Non - Ablative resurfacing laser treatment ..... ☐YES ☐NO
Treatment name:_____ Location treated:_____ Date of last treatment _____
Dermabrasion or deep facial peels..... ☐YES ☐NO
Treatment name:_____ Location treated:_____ Date of last treatment _____
Lipoplasty in the face or neck regions..... ☐YES ☐NO
Treatment name:_____ Location treated:_____ Date of last treatment _____
Facelift or blepharoplasty or brow lift..... ☐YES ☐NO
Treatment name:_____ Location treated:_____ Date of last treatment _____

Are you currently taking the following prescription medications:

Accutane within the last 12 months..... ☐YES ☐NO
Anticoagulants or antiplatelet drugs..... ☐YES ☐NO
Immunosuppressant drugs..... ☐YES ☐NO

List all medications or supplements below. Be sure to include all prescription or non-prescription medications
If you are not taking any medications or supplements please check here: ☐

Medication	Disease/Reason	Dose	Frequency	Date started	Date last taken

*Ultherapy® is contraindicated for use
** Ultherapy® is not recommended for use directly over this
*** Ultherapy® has not been evaluated for use in this scenario

Ultherapy® Consult Record

Self-Exam

As every patient is different, the clinical factors listed below are intended to assist your clinician in forecasting your clinical response to Ultherapy. Please score each clinical factor listed below. Upon examination of your responses, your physician will discuss your options for achieving optimal results with Ultherapy.

Clinical Response Factors: Circle the appropriate answer below

Age:	<35 y/o	35-49 y/o	50-64 y/o	65+ y/o
Smoking History:	Never smoked	Ex-smoker	Light smoker	Heavy smoker
Health:	No health issues	Minor health issues	Chronic health issues	
Sun exposure:	Never use sun screen	Occasionally use sun screen	Always use sun screen	

Clinical Response Factors – Upper face: Check the appropriate box	**None**	**Mild**	**Moderate**	**Severe**
Skin Laxity: Excess skin or hooding on the eyelid; eyelid droopiness				
Volume: Presence of fat deposits under eyes; infra-orbital puffiness				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				
Clinical Response Factors – Lower face and neck: Check the appropriate box	**None**	**Mild**	**Moderate**	**Severe**
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				
Volume: Presence of fat deposits in lower face, loss of jaw definition, and/or excessive sub-Q fat				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				

What are your treatment goals:_____

_____

Additional findings:

_____

_____

_____

_____

Patient Signature: _____ Date:_____

Ultherapist Signature: _____ Date:_____

Physician Signature: _____ Date:_____

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Ultherapy® Consult Record

THIS SECTION FOR HEALTH-CARE PROFESSIONAL USE ONLY

Treatment checklist

Pre-treatment photos taken…… ☐YES ☐NO
Procedure reviewed with patient: …… ☐YES ☐NO
Patient questions answered: …… ☐YES ☐NO
Informed Consent signed: …… ☐YES ☐NO
Photo Consent signed: …… ☐YES ☐NO
Ultherapy™ treatment date: _____
Pre-Medication Order: _____
Ultherapy™ Treatment Record from System printed: …… ☐YES ☐NO
Ultherapy™ Patient Record completed: …… ☐YES ☐NO
"What to Expect" pamphlet instruction given to patient:…… ☐YES ☐NO

Follow up checklist

Aesthetic care plan discussed:_____
_____
_____
3 month follow-up appointment scheduled:_____
1st follow-up visit date:_____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐R90
2nd follow-up visit date:_____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐R90

Clinical and treatment notes:

_____

_____

_____

_____

_____

Ultherapist Signature: _____ Date:_____

Physician Signature: _____ Date:_____

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