

Microneedling Contraindications

Precautions:

Suspicious Lesions- These must be diagnosed by a practitioner prior to beginning treatment.

Discontinue autoimmune therapies and retinoid products 24 hours prior to beginning treatment.

Do not treat over active acne, rosacea, or other inflammatory conditions.

Do not treat over open wounds.

Do not use the device inside of orbital rim, such as eyelids or inside the vermilion border of the lips.

Consider prophylactic treatments for those clients prone to viral breakouts.

Treatments are not to be administered for at least 6 months after the use of Accutane.

Contraindications:

Keloid scars.

Active eczema.

Psoriasis and other chronic conditions.

History of actinic or solar keratosis.

History of herpes simplex infections.

History of diabetes.

Presence of raised moles in area to be treated.

Absolute Contraindications:

Scleroderma, collagen or vascular diseases and cardiac abnormalities.

Blood clotting conditions.

Active bacterial or fungal infections.

Immunosuppression.

Not recommend for women who are pregnant or nursing.



POST CARE

Clients should take extra precautions to guard against sun exposure immediately following their microneedling, as the treated area will be more sensitive the first 48 hours following the treatment. It is imperative that you use a mild sunscreen with a 30SPF or higher and avoid any direct sunlight during the course of treatment.

To achieve the best results and to protect your skin, sun block is recommended as part of your every day skin care routine.

Do not use skin exfoliants or scrubs for 10-14 days after treatment.

No heat exposure (hot tubs, saunas, steam or excessive exercise) for a minimum 48 hours after treatment.

Please clean anything that may come in contact with your face (phones, glasses) with alcohol pads and change your pillowcase the night of the procedure if a facial treatment was performed. We want to keep your treatment area as clean as possible as it will lessen the chances of breakouts.

You should keep your skin free of any makeup or additional products not applied after the treatment for a minimum of 12 hours.

General Information

Potential side effects may include: redness, swelling, burning, mild bruising and skin sensitivity, which can last 1-3 days. If you feel that you are having a negative reaction, please call our office so that we may assist you.

Mild swelling is expected immediately following the treatment and generally calms within 24 hours, but can persist longer. There may also be some mild to moderate peeling or flaking of the skin noticed after the treatment.

Clients may experience significant redness in the treatment area for up to 3-7 days after treatment. This redness may persist longer in treatment areas other than the face.

As with any treatments, the response, results and healing after a microneedling treatment varies with each individual and a specific outcome is not guaranteed.



_____The Client understands that the number of micro-needling treatments required varies and that several treatments may be needed.

_____The Client understands that there may be some degree of discomfort, (i.e., scratchiness, itchiness, irritation, stinging and hotness.)

_____The Client understands that it is normal for the treated area to appear red with slight swelling after the treatment, similar to mild-moderate sunburn, which can last for up to 4 days following treatment. There may also be very mild temporary bruising.

_____The Client understands that this procedure does not come with any guarantees and understands in order to achieve maximum results, they will need maintenance treatments and the use of daily recommended products.

_____The Client understands that exposure of a recently treated area to direct sunlight should be avoided and that we advise the use of an SPF of 30 or higher.

_____The Client confirms that they have informed Renew Day Spa of all their medical details relevant to this treatment and will inform Renew Day Spa of any changes throughout the duration of the treatments should any information change.

_____The Client confirms that they have understood all the information given regarding this treatment during the consultation and that any questions that have been presented have been answered satisfactorily.

_____The Client agrees to have the treatment performed as outlined above, including the use of a topical anesthetic if required and will follow all prescribed directions regarding post-procedure care and home care.

_____The Client understands that there are other treatment options available, including doing no treatment at all.

_____The Client acknowledges that they have read and fully understood this document before signing.

Client name (printed)

Date

Client signature

Provider signature
