CALIFORNIA HAIR AND SKIN INSTITUTE

INFORMED CONSENT FOR PLATELET-RICH PLASMA (PRP) HAIR RESTORATION TREATMENT

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Procedure Date: _____

Treating Physician: Vakas Sial, MD

PURPOSE OF THIS CONSENT

This document explains the benefits, risks, alternatives, and limitations of Platelet-Rich Plasma (PRP) therapy for hair restoration.

Please read this document carefully and ask any questions before signing.

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1. NATURE OF THE PROCEDURE

I authorize Dr. Vakas Sial and qualified members of the California Hair and Skin Institute clinical team to perform Platelet-Rich Plasma (PRP) therapy when medically appropriate.

PRP therapy involves:

- Collection of a sample of my own blood
- Processing of the blood to concentrate platelets
- Injection of concentrated platelets into targeted areas of the scalp

Platelets contain growth factors that may support tissue healing and hair follicle function.

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2. EXPECTED BENEFITS

I understand PRP therapy may:

- Improve hair quality
- Support existing hair follicles
- Support transplanted hair follicles
- Improve hair thickness or density in some patients

I understand:

- Individual response varies.
- Multiple treatments may be recommended.
- Results cannot be guaranteed.

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3. RISKS AND POSSIBLE SIDE EFFECTS

Possible risks include:

- Temporary soreness
- Swelling
- Bruising
- Bleeding
- Headache
- Infection
- Temporary scalp tenderness
- Temporary shedding
- Lack of improvement

Although uncommon, no guarantee can be made that complications will not occur.

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4. ALTERNATIVES

Alternative treatments may include:

- No treatment
- Hair fibers or camouflage products
- Hair systems
- Low-level laser therapy
- Hair transplantation
- Hair loss medications
- Observation

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5. NO GUARANTEE OF RESULTS

I understand:

- Medicine is not an exact science.
- Results vary among individuals.
- No guarantees or warranties have been made regarding outcomes.
- Additional treatments may be recommended.

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6. FOLLOW-UP CARE

I agree to:

- Follow all post-treatment instructions.
- Attend recommended follow-up appointments.
- Notify the office of unexpected symptoms.
- Follow medical recommendations.

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7. QUESTIONS AND CONSENT

I certify that:

- I have had sufficient opportunity to ask questions.
- My questions have been answered.
- I understand the risks, benefits, alternatives, and limitations of PRP therapy.
- I voluntarily consent to treatment.

PATIENT CONSENT

I authorize Dr. Vakas Sial and the California Hair and Skin Institute clinical team to administer Platelet-Rich Plasma therapy when medically appropriate.

Patient Signature: _____

Printed Name: _____

Date: _____

PHYSICIAN CERTIFICATION

I certify that I have discussed the nature of the proposed treatment, anticipated benefits, material risks, alternatives, and answered the patient's questions.

Physician: Vakas Sial, MD

Signature: _____

Date: _____