CALIFORNIA HAIR AND SKIN INSTITUTE

INFORMED CONSENT FOR HAIR TRANSPLANTATION (FUE)

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 hair transplantation procedures, including Follicular Unit Extraction (FUE).

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 hair restoration surgery deemed medically appropriate.

The procedure may include:

- Follicular Unit Extraction (FUE)
- Harvesting individual follicular units from the donor area
- Preparation and placement of follicular grafts into areas of hair loss
- Use of local anesthesia as medically necessary
- Any medically necessary modifications required to safely complete treatment

I understand that hair transplantation involves moving existing hair follicles from one area of my scalp to another. The transplanted follicles may continue to grow hair; however, results vary among individuals.

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2. EXPECTED BENEFITS

The goals of hair transplantation may include:

- Improvement in areas of hair thinning or loss
- Increased hair density
- Natural-looking restoration of hair coverage

I understand that individual results vary and that complete restoration of hair density may not be possible.

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3. RISKS AND POSSIBLE COMPLICATIONS

I understand that, as with any medical procedure, complications may occur.

Possible risks include:

- Pain or discomfort
- Swelling
- Bruising
- Bleeding
- Infection
- Scarring
- Changes in scalp sensation
- Temporary numbness
- Poor graft growth or graft failure
- Uneven hair density
- Unnatural appearance
- Temporary shedding of transplanted or existing hair (“shock loss”)
- Need for additional procedures
- Dissatisfaction with cosmetic outcome

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

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4. ALTERNATIVES

Alternative options may include:

- No treatment
- Hair fibers or camouflage products
- Hair systems
- Low-level laser therapy
- Medication therapy

- PRP therapy
- Observation

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5. NO GUARANTEE OF RESULTS

I understand:

- Medicine is not an exact science.
- Hair growth varies among individuals.
- No guarantees or warranties have been made regarding my results.
- Additional procedures or treatments may be recommended.
- The final cosmetic outcome cannot be guaranteed.

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6. FOLLOW-UP CARE

I agree to:

- Follow all postoperative instructions provided by the medical team.
- Attend recommended follow-up appointments.
- Notify the office of unexpected symptoms or concerns.
- Follow medication instructions as directed.

Failure to follow postoperative instructions may negatively affect my outcome.

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7. MEDICAL HISTORY

I certify that I have informed my physician of:

☐ Allergies
☐ Current medications
☐ Supplements
☐ Bleeding disorders
☐ Heart disease
☐ Liver disease
☐ Kidney disease
☐ Pregnancy or plans for pregnancy
☐ Previous reactions to anesthesia
☐ Previous hair restoration procedures

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8. QUESTIONS AND CONSENT

I certify that:

- I have had sufficient opportunity to ask questions.
- My questions have been answered to my satisfaction.
- I understand the risks, benefits, alternatives, and limitations of hair transplantation.
- I voluntarily consent to this procedure.

PATIENT CONSENT

I authorize Dr. Vakas Sial and the California Hair and Skin Institute clinical team to perform hair transplantation procedures, including FUE, 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: _____