CALIFORNIA HAIR AND SKIN INSTITUTE

INFORMED CONSENT FOR LOCAL ANESTHESIA

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, and limitations associated with the use of local anesthetic medications during hair restoration procedures.

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1. NATURE OF THE PROCEDURE

I understand local anesthetic medications may be administered to reduce discomfort during procedures.

Medications may include:

- Lidocaine
- Bupivacaine
- Similar anesthetic agents
- Medications with or without Epinephrine

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2. RISKS AND POSSIBLE COMPLICATIONS

Possible risks include:

- Pain during injection
- Bruising
- Swelling
- Bleeding

- Temporary numbness
- Temporary nerve irritation
- Infection
- Allergic reaction
- Vasovagal reaction (lightheadedness or fainting)
- Rare cardiovascular complications
- Extremely rare severe allergic reactions requiring emergency treatment

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

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3. ALTERNATIVES

Alternatives may include:

- No anesthesia
- Alternative pain management methods
- Delaying or declining treatment

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4. QUESTIONS AND CONSENT

I certify that:

- I understand the purpose of local anesthesia.
- I understand possible risks and complications.
- My questions have been answered.
- I voluntarily consent to the use of local anesthesia.

PATIENT CONSENT

I authorize Dr. Vakas Sial and the California Hair and Skin Institute clinical team to administer local anesthesia when medically appropriate.

Patient Signature: _____

Printed Name: _____

Date: _____

PHYSICIAN CERTIFICATION

Physician: Vakas Sial, MD

Signature: _____

Date: _____