INFORMED CONSENT FOR HAIR TRANSPLANTATION SURGERY

Patient Name:

_____

Date of Birth: //_____

Date of Procedure: //_____

Surgeon Name:

_____

1. Description of the Procedure

I hereby authorize Dr. _____ and their designated surgical assistants or technicians to perform a hair transplantation procedure on me.

The planned method of donor harvesting is (Please check/initial one):

- **[ ] Follicular Unit Excision (FUE): Individual hair follicles are extracted directly from the donor area using manual or motorized punch tools, leaving tiny, dot-like micro-scars.**
- **[ ] Follicular Unit Transplantation (FUT / Strip): A strip of skin containing hair follicles is surgically removed from the donor area (usually the back of the head) and closed with sutures/staples, leaving a permanent linear scar.**

The extracted hair grafts will be artistically prepared under microscopes and transplanted into the agreed-upon recipient area(s) of my scalp.

2. Patient Acknowledgments & Expectations

Please initial each box to confirm your understanding:

- **[ ] No Guarantee of Results: I understand that medicine and surgery are not exact sciences. I acknowledge that no guarantee or promise has been made to me regarding the final aesthetic outcome, graft survival rate, or exact hair density.**
- **[ ] Redistribution, Not New Hair: I understand that a hair transplant redistributes existing active hair follicles from my donor area to balding areas. It does not create new hair follicles, nor will it restore my original, pre-hair-loss density.**
- **[ ] Progressive Hair Loss: I understand that male/female pattern baldness is a progressive condition. While transplanted hair is generally permanent, my native, non-transplanted hair may continue to fall out over time, which may require medical maintenance (e.g., finasteride, minoxidil) or future transplant procedures.**
- **[ ] Timeline for Results: I understand that transplanted hairs typically shed within 3–4 weeks after the procedure. New growth begins around 3–4 months, and the final aesthetic outcome cannot be accurately evaluated until 12 to 18 months post-surgery.**

3. Risks and Potential Complications

I acknowledge that while hair transplantation is generally a safe, outpatient procedure, it carries inherent risks. These include, but are not limited to:

1 Bleeding & Infection: Minor bleeding, oozing, and localized infection at the donor or recipient sites.

2 Swelling: Temporary swelling of the scalp, forehead, and around the eyes, which typically peaks 2–5 days post-op.

3 Scarring: Permanent scars will exist at the donor and recipient sites. While hidden by surrounding hair, scarring may become visible with short haircuts. Rare keloid or hypertrophic (raised) scarring can occur.

4 Shedding ("Shock Loss"): Temporary shedding of existing native hair in either the recipient or donor areas due to surgical trauma. This hair usually regrows within 3–4 months, though extremely weak hairs may not return.

5 Numbness: Temporary numbness, tightness, or altered sensation in the scalp. This typically resolves over several weeks to months, but in extremely rare cases, it can be permanent.

6 Cysts & Folliculitis: Small, sterile pimples or cysts may form around the new grafts during the first few months. These are usually easily treated.

7 Poor Graft Survival: Some or all of the transplanted hair may fail to grow due to poor

vascularity, poor post-operative care, or unpredictable healing factors.

8 Anesthesia Risks: Local anesthetics (e.g., lidocaine) carry risks of allergic reaction, dizziness, rapid heart rate, or, in rare cases of systemic toxicity, more severe complications.

4. Alternative Treatments

I understand that I have alternative options to address my hair loss, including:

- **Choosing to do nothing and accepting the hair loss.**
- **Non-surgical medical therapies (e.g., Minoxidil, Finasteride, Dutasteride).**
- **Cosmetic solutions such as hairpieces, wigs, or scalp micropigmentation (SMP).**

5. Post-Operative Care Compliance

I understand that the ultimate success of this procedure heavily relies on my strict adherence to the post-operative instructions provided by the clinic. This includes:

- **Avoiding touching, rubbing, or scratching the newly placed grafts.**
- **Sleeping with my head elevated for the first few nights.**
- **Avoiding strenuous physical activity, heavy lifting, and direct sun exposure as instructed.**

- **Taking prescribed antibiotics, anti-inflammatories, or pain medications exactly as directed.**

6. Consent to Photography & Media

I consent / do not consent (please circle one) to the taking of clinical photographs and videos before, during, and after my procedure. I agree that these may be used for medical records, clinical education, or the clinic's marketing and portfolio, provided my identity is kept strictly confidential.

7. Signatures & Informed Consent Statement

By signing below, I certify that:

1 I have read this entire consent form, or it has been read to me, and I fully understand it.

2 I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

3 I am not under the influence of any drugs, alcohol, or medications that would impair my judgment or ability to give informed consent.

4 I voluntarily consent to undergo the hair transplantation procedure as described.

Patient Signature:

_____

Date: //_____

Witness Signature:

_____

Date: //_____

Surgeon/Physician Signature:

_____

Date: //_____