Dr Gary Groenewald
Gynaecologist • Obstetrician • Endoscopic Surgeon

Alma Lasers™
Wellbeing Through Technology

Patient History | Femilift

Patient name	D.O.B	Patient Reference ID

(Please answer ALL questions in this section)	Yes	No	*Please give full details, dates, hospitals consulted etc*
Are you pregnant or think you may be pregnant?			
Are you breast feeding?			
When was the date of your last menstrual cycle?			

	Yes	No	*If "yes" please give full details, dates, hospitals consulted etc*
Have you recently had any gynaecological treatments or surgery?	Yes	No	
Are you using aspirin or any blood thinning medication?			
Do you have any general medical history? (eg Epilepsy, Diabetes, Hypertension, Pregnancy)			
Do you have any type of immune deficiency? (eg HIV or Hepatitis)			
Do you have any allergies?			
Do you have any Hormone abnormalities?			
Do you take any prescribed or non prescribed medication or herbal remedies? (eg St Johns wart)			

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Reason(s) for treatment

Please state the type of treatment that you intend to have today (if unsure leave blank)
Dr Gary Groenewald strives to provide the best appropriate medical care for all patients requiring aesthetic medical treatments, please can you indicate by completing the following section your reason for requiring aesthetic medical treatment today, which will help us to confirm that VAT is not applicable to your treatment. The price quoted to you is on the basis that your treatment is for medical reasons and thus VAT would not be applicable.

Please tick the following that apply	
I am seeking treatment to improve my condition.	
My current condition is causing my mood to be low.	
My current condition is reducing my confidence when interacting with others.	
If the problem with my condition is improved I think that my mood will improve.	
If the problem with my condition is improved I think my self-confidence will improve.	
If the problem with my condition is improved I think that I will feel more confident when interacting with others.	
If the problem with my condition is improved I think my self-esteem will improve.	
The primary reason that I am seeking treatment is to improve my self-esteem, confidence and/or mood.	

	Yes	No
If you have ticked no to all of the above, are you looking to improve your general well being?		
The practitioner has explained the need for these medical treatments and I fully understand the implications.		

I confirm that all of the information I have given is accurate to the best of my knowledge and I will ensure that I advise my practitioner of any changes.

Patient

Signature:______________________ Print Name:__________________________Date: / /

Practitioner

Signature:______________________ Print Name:__________________________Date: / /

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Patient Name .... Clinic ....

Patient Consent for Femilift Treatment

This agreement is between Dr Gary Groenewald, Practitioner ____ hereafter known as the 'Patient'.

I confirm that I have read and understand the following

I voluntarily request Co2 laser treatment for vaginal remodeling/treatment of stress urinary incontinence.

I voluntarily consent and authorize that this Co2 laser assisted treatment be performed by the staff of this clinic, including physicians, technicians, associates, technical assistants, and other health care providers as deemed necessary by the staff of this clinic.

I hereby release this clinic, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.

I recognize that this Co2 laser assisted treatment is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result or cure. There are risks related to the performance of these procedures. I understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:

Infection – Albeit rare, skin infection is a possibility any time a skin procedure is performed. I acknowledge and understand that although rare, it is possible for a skin infection to become a blood-borne wide spread infection.

Blood clots in veins and lungs – Albeit extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.

Allergic reactions – Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me

Hemorrhage and bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I (we) have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.

Recurrence of the lesion – I may not experience permanent results even with multiple treatments.

Painful or unattractive scarring – Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow all postoperative instructions carefully.

Discomfort and pain – Some discomfort may be experienced during and after the laser treatment. I give my permission for the administration of topical and/or local injection of anesthesia when and if deemed appropriate.

Pigment changes (skin color) – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

Poor healing – The resultant open wound may require more than the usual one to three weeks to heal.

Blindness and eye damage – The laser, without protective eyewear, may cause visual loss including blindness. ***It is important to keep these shields on at all times*** during the procedure and that ***I should keep my eyes closed*** in order to protect my eyes from accidental laser exposure.

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Patient Consent for Femilift Treatment Continued...

I have been given an opportunity to ask questions about my condition and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give the informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all of the disclosures referred to herein. I certify that I am a competent adult of at least 18 years of age.

	Yes	No
I have discussed my medical history fully with my practitioner.		
My practitioner has advised me of the possible side effects or complications of my treatment related to the above medical conditions.		
I hereby consent to treatment with Co2 laser for vaginal remodeling/treatment of stress urinary incontinence.		

I am signing this consent form prior to treatment and acknowledge that by signing this agreement, I fully understand its contents.

Patient

Signature:________________________ Print Name:_____________________________ Date: / /

Practitioner

Signature:________________________ Print Name:_____________________________ Date: / /

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Femilift | Initial Consultation

Patient name	Date	D.O.B
Patient Reference ID		

Consultation Notes

Price of treatment	Total £
Practitioner	

Signature: ______________________ Print Name:__________________________Date: / /