Cryopen

CRYOPEN

Status: active Form type: default Company: Acme Inc Disclaimer About the CryoPen Treatment CryoPen treatment uses advanced cryotherapy technology to remove benign skin lesions by delivering a highly accurate jet of nitrous oxide. The process freezes and destroys unwanted tissue while preserving surrounding healthy skin. This minimally invasive procedure is commonly used to treat: Skin tags Warts and verrucae Sunspots or age spots Seborrheic keratosis Cherry angiomas The treatment is typically quick, lasting from 5 to 30 seconds per lesion depending on size and depth. Most patients experience minimal discomfort during the procedure, often described as a stinging or cold sensation. What to Expect During and After Treatment During Treatment: Your practitioner will cleanse the area and position the CryoPen for precise application. A brief cold sensation will be felt as the nitrous oxide targets the lesion. Immediately After Treatment: The treated area may appear red or swollen and may form a blister. Some lesions may darken before naturally sloughing off over 1-4 weeks. Long-Term Outcomes: Treated lesions are expected to heal without complications if aftercare guidelines are followed. Complete healing time varies based on the lesion and individual skin healing processes. Potential Risks and Side Effects CryoPen treatment is generally safe, but as with any procedure, there are potential risks, including: Temporary redness, swelling, or tenderness at the treatment site Formation of blisters or scabs, which will naturally heal Skin discolouration, either temporary or permanent Rare cases of minor scarring Risk of infection if the site is not properly cared for Pre-Treatment Acknowledgements I confirm that I: Have provided accurate medical history, including any known allergies or sensitivities. Understand that CryoPen is not suitable for all skin conditions, and my practitioner has determined my suitability. Have been informed that results may vary and that multiple treatments may be required for larger or stubborn lesions. Post-Treatment Care I understand the importance of post-treatment care, including: Keeping the treated area clean and dry. Avoiding touching, scratching, or picking at the site to prevent infection or scarring. Protecting the area from direct sunlight and applying sunscreen as recommended. Contacting my practitioner if I experience excessive redness, swelling, or signs of infection. I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: - the aims/motivations for having the procedure and the desired outcome - the risks inherent in the procedure - the risks inherent in refusing the procedure - the risks specific to me - the expected benefits of the treatment - the potential disadvantages of the treatment - alternative procedures and their pros and cons - including the option of no treatment at all - any uncertainties about and the likelihood of success of the procedure - any follow-up treatment that may be required CLINICAL PHOTOS AND VIDEOS: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records. I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my s have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.