Neograft

NEOGRAFT

Status: active Form type: default Company: Acme Inc

Procedure Information: NeoGraft is a minimally invasive hair restoration procedure that uses automated Follicular Unit Extraction (FUE) technology to harvest hair follicles from a donor area (typically the back of the scalp) and transplant them to areas of thinning or balding. The procedure does not require a scalpel incision or stitches, which may result in less downtime and no linear scar. Risks and Side Effects: Possible risks include temporary swelling, redness, bleeding, bruising, discomfort, infection, folliculitis, scabbing, numbness, and shock loss (temporary shedding of transplanted hair). There may also be variability in graft survival rates, asymmetry, and an unsatisfactory cosmetic outcome. Hair regrowth is gradual and results may vary between individuals. Contraindications: NeoGraft is not suitable for individuals with certain scalp conditions, uncontrolled medical problems, or insufficient donor hair supply. Those with unrealistic expectations or unstable hair loss patterns should discuss their concerns with the practitioner before proceeding. Aftercare: Avoid touching, scratching, or picking at the treated area. Follow all post-procedure care instructions provided by your practitioner, including proper washing techniques. Avoid strenuous activity, sun exposure, and swimming for the time period recommended. New hair growth typically begins at 3–4 months post-procedure, with full results visible in 9–12 months.

Informed Consent and Photography 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 Photographs 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 questions 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.