Toskani

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Status: active Form type: default Company: Acme Inc

Toskani® is a professional skincare and aesthetic brand offering advanced mesotherapy cocktails, cosmeceuticals, and chemical peels. These treatments are designed to address various skin concerns including fine lines, pigmentation, acne, dehydration, hair loss, and skin ageing. Treatments may involve microneedling, intradermal injection, or topical application, depending on the product and indication. Results may be visible after a few sessions but can vary based on individual skin type, age, and overall health. Medical Considerations and Contraindications This treatment is not suitable if you are pregnant or breastfeeding, are under 18 years of age, have allergies to any of the ingredients in the Toskani® product, have an active skin infection or inflammation in the area to be treated, have a history of keloid scarring, are undergoing treatment for cancer, have autoimmune conditions or bleeding disorders, or are currently taking anticoagulants or immunosuppressants. Potential Risks and Side Effects Temporary and expected effects include redness, swelling, sensitivity, bruising, or a warm sensation in the treated area. These effects typically resolve within a few hours to a few days. In some cases, clients may experience minor itching, flaking, or dryness as part of the normal healing process. Rare side effects may include infection, allergic reaction, post-inflammatory hyperpigmentation, or prolonged swelling. If any unusual or concerning symptoms occur, you should contact your practitioner immediately. Aftercare Advice Keep the treated area clean and avoid applying makeup or skincare products (unless advised) for at least 24 hours. Avoid excessive sun exposure, hot baths, steam rooms, and physical exertion for 48 hours. Apply sunscreen daily and follow any specific aftercare instructions provided by your practitioner. Do not pick or scratch the skin, and avoid using exfoliants or active ingredients (such as retinol or AHAs) for several days post-treatment. 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 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.