

# Waxing Consent Form

Read every section before signing. Ask your clinician to explain anything that is unclear, and keep a copy of the signed form for your records.

Name: \_\_\_\_\_ Date completed: \_\_\_\_\_ dd / mm / yyyy

Date of birth: \_\_\_\_\_ dd / mm / yyyy Record / MRN number: \_\_\_\_\_

Procedure or service: Waxing

Proposed date: \_\_\_\_\_ dd / mm / yyyy Clinician responsible: \_\_\_\_\_

## 1. WHAT IS BEING PROPOSED

Your clinician will describe what the Waxing procedure involves, how long it is expected to take and what you will notice afterwards.

Description discussed

## 2. BENEFITS AND EXPECTED OUTCOME

No outcome can be guaranteed. The benefits discussed with you are recorded here.

Benefits discussed

## 3. RISKS AND SIDE EFFECTS

Confirm that each of the following has been explained to you.

Risks and side effects confirmed

- ☐ Common side effects and how long they usually last
- ☐ Uncommon but serious risks specific to this procedure
- ☐ What to do, and who to contact, if a complication occurs
- ☐ The likely recovery period and any activity restrictions

Additional risks specific to me

## 4. ALTERNATIVES

Alternatives confirmed

- ☐ Alternative treatments have been explained to me
- ☐ The option of having no treatment has been explained to me
- ☐ I have had the opportunity to ask questions and they were answered

## 5. PHOTOGRAPHY

I agree to clinical photographs being taken for my records.

☐ Yes ☐ No

I agree to anonymised photographs being used for teaching or marketing.

☐ Yes ☐ No

## 6. RELEVANT MEDICAL HISTORY, MEDICATION AND ALLERGIES

Relevant medical history, medication and allergies

I confirm that I have read and understood this form. I have had the procedure, its risks, its benefits and the alternatives explained to me in language I understand.

I understand that I may withdraw my consent at any time before the procedure begins, and that no guarantee has been given about the result.

## SIGNATURES

\_\_\_\_\_  
Patient signature and date

Complete only where the patient is under 18 or lacks capacity to consent.

\_\_\_\_\_  
Clinician signature and date

\_\_\_\_\_  
Parent / guardian signature and date

Relationship to patient: \_\_\_\_\_