

## **Microblading**

### **Before Care**

- Do not work out on the day of the procedure
- Do not drink too much coffee on the day of the procedure
- Do no tan (no sun) for one week prior to the procedure
- Do not take aspirin, niacin, vitamin E or ibuprofen 24 hours before procedure
- No alcohol the night prior or the day of the procedure
- Any waxing or tinting of the brows should be done 3 days prior
- No Botox for 4 weeks prior to the procedure
- It is best to do a scrub 3 days prior to the procedure
- Stop using any Retin-A or AHA products for 2 weeks prior to the procedure
- No lasers or chemical peels for 1 month prior to the procedure
- No microdermabrasion or dermaplaning for 2 weeks prior

### **After Care Instructions**

- Clean the treatment area on the night of procedure and daily thereafter. Apply a thin layer of after-care balm, grapeseed or coconut oil to the treatment area twice daily (once if you have oily skin), being careful not to over saturate. A thin layer is all you need.
- Besides gently cleansing the procedure area daily, keep water off of your brows for the next 5 days. That includes sweating, saunas and hot showers.
- Do not use any face creams, exfoliators, or harsh cleansers on your brows during the healing process.
- Normal activity can be resumed immediately, but no heavy exercise such as aerobic dancing, weight lifting, swimming, etc. for the next 10 days.
- Your procedure will begin to oxidize immediately. This causes the pigment to become darker. Do not be alarmed, this dark color will fade during the next few days.
- Do not pick any scabs or dry areas that may form during the healing process. This may cause you to lose color or damage your skin. Instead, apply some of the after-care your technician gave you after the procedure.
- Other fading or loss of pigment may occur. Some flaking off of the pigment is normal on some skin types the pigment may sometimes disappear, only to reappear a few days or weeks later. Any pigment loss will be recovered at touch up.

## **5 ELEMENTS MICROBLADING INTAKE FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Do you have or previously had any of the following (circle YES or NO)

**YES NO** History of MRSA      **YES NO** Diabetes      **YES NO** Easy Bleeding

**YES NO** Hepatitis A B C D      **YES NO** Facelift      **YES NO** Alcoholism

**YES NO** Forehead/Brow lift      **YES NO** Abnormal Heart Condition      **YES NO** Brow Lash Tinting

**YES NO** Autoimmune disorder      **YES NO** Oily Skin      **YES NO** Tan by booth or salon

**YES NO** Pregnant now – Breastfeeding now      **YES NO** Tumors/Growth/Cysts

**YES NO** Take medication before dental work      **YES NO** Accutane or acne treatment

**YES NO** Chemotherapy/ Radiation      **YES NO** Difficulty numbing with dental work

**YES NO** Chemical Peel (last treatment \_\_\_\_\_)

**YES NO** Botox (last treatment \_\_\_\_\_)

**YES NO** Cancer (Year \_\_\_\_\_)

**YES NO** Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin, etc.

**YES NO** Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc

\_\_\_\_\_  
**YES NO** Allergies to metals, food, etc

\_\_\_\_\_  
**YES NO** Any diseases or disorders not listed

\_\_\_\_\_  
**YES NO** Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?

Please list any medications you are taking:

\_\_\_\_\_  
I agree that all the above information is true and accurate to the best of my knowledge

Signed \_\_\_\_\_ Date \_\_\_\_\_

## **Tattoo Consent Form**

I \_\_\_\_\_ (Client) hereby consent to and authorize  
\_\_\_\_\_ (tattoo artist) to perform the following procedure:  
\_\_\_\_\_

\_\_\_\_\_ (initials): I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved.

\_\_\_\_\_ (initials): Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle.

\_\_\_\_\_ (initials): I understand that this is a **2** and sometimes **3-step process** and I will be required to return no later than **60 days** after initial procedure for further treatments to obtain the expected results. **Anytime past the 60-day period will require payment.**

\_\_\_\_\_ (initials): I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drug or products I am currently ingesting or using topically.

\_\_\_\_\_ (initials): I acknowledge that the proposed procedure involves risks inherent in the procedure and have possibilities of complications during and/or following the procedure such as: infection, poor color retention and hyper-pigmentation.

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history.

Client Name (printed) \_\_\_\_\_ Date \_\_\_\_\_

Client Name (signature) \_\_\_\_\_ Date \_\_\_\_\_

Technician/Tattoo Artist \_\_\_\_\_

## **MODEL PHOTO RELEASE FORM**

I hereby give permission to \_\_\_\_\_ (tattoo artist) to use my photographic likeness in all forms and media for advertising, exposition displays, trade, teaching materials and any other lawful purposes.

**Model will not receive any compensations in return for use of images.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Possible Risks, Hazards, or Complications

- **Pain:** There can be pain even after the topical anesthetic has been used. Anesthetics work better on some people than others.
- **Infection:** Infection is very unusual. The areas treated must be kept clean, and only freshly cleaned hands should touch the areas. See “After Care” sheet for instruction on care.
- **Uneven Pigmentation:** This can result from poor healing, infection, bleeding, or many other causes. Your follow-up appointment will likely correct any uneven appearance.
- **Asymmetry:** Every effort will be made to avoid asymmetry, but our faces are not symmetrical, so adjustments may be needed during the follow-up session to correct any unevenness.
- **Excessive Swelling or Bruising:** Some people bruise or swell more than others. Ice packs may help reduce the swelling. The swelling or bruising typically disappears in 1-5 days. Some people don’t bruise or swell at all.
- **Anesthetics:** Topical anesthetics are used to numb the area to be tattooed. Lidocaine, Prilocaine, Benzocaine, Tetracaine, and/or Epinephrine cream and/or liquid are used. If you are allergic to any of these, please inform me now.
- **MRI:** Because pigments used in Permanent Cosmetic procedures contain inert oxides, a low-level magnet may be required if you need to be scanned by an MRI machine. You must inform your MRI Technician of any tattoos or permanent cosmetics.

The alternative to these possibilities is to use traditional cosmetic and **NOT** undergo the Semi-Permanent Eyebrow procedure.

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history

Signed \_\_\_\_\_ Date \_\_\_\_\_