EXION™

FRACTIONAL RF APPLICATOR

PATIENT TREATMENT RECORD

Patient's name:	**Date of birth:**
Phone:	**Email:**

You are scheduled for a series of mini-invasive treatments with the **EXION Fractional RF Applicator**. The EXION Fractional RF applicator used with the Non-insulated and Insulated single-use tips is intended for use in dermatological and general surgical procedures for electrocoagulation and hemostasis. **Initials:**_____

Your treatment provider will discuss your specific treatment needs. A recommended course of treatment typically involves 2 - 5 sessions, with a one to six-week interval between each session depending on the individual's healing process. **Initials:**_____

The area of interest must be free from hair, make-up, creams, and lotions. I acknowledge that I have been advised to shave the area prior to the procedure, or the area will be shaved at the procedure visit. **Initials:**_____

On the day of the treatment, you are advised to wear comfortable clothing so the treatment area can be easily accessed. Also, the treated area will be wiped with a cleanser before treatment to remove any moisture, perfume, moisturizers, or oils. You will be asked to remove all metallic accessories and electronic devices. **Initials:**_____

The treatment may be associated with some level of discomfort. A topical anesthetic in the form of numbing cream may be used when needed. Following the Fractional RF treatment, it is common for patients to experience varying degrees of erythema (redness) and edema (swelling). Additionally, visibility of small crusts, blisters, or burns occasionally develop at contact locations. These typically slough within one week for sensitive skin. **Initials:**_____

I am aware NOT TO wear any metallic accessories (such as jewelry, watch or clothes containing metallic threads or metallic accessories) during the treatment. I also acknowledge that I do not have any metallic or electronic implants near the treatment area (such as pacemakers, defibrillators, etc.). **Initials:**_____

Following the treatment, it is recommended to avoid sun exposure or any excessive tanning for several days after the treatment. A broad-spectrum UVA/UVB sunblock should be used outdoors until the skin is completely healed. Patients should also avoid skin irritation in the treated area for 24-48 hours after therapy and may apply makeup only 24-72 hours after each session if the skin is not broken. While regular soaps are fine, scrub soaps or exfoliants should be generally avoided for 24 hours after treatment. **Initials:**_____

Please answer whether you currently have or have had any of the following in the past*:

	YES	NO
Bacterial or viral infection, acute inflammations	○	○
Impaired immune system	○	○
Isotretinoin in the past 12 months	○	○
Skin-related autoimmune diseases	○	○
Radiation therapy and chemotherapy	○	○
Poor healing and unhealed wounds in the treatment area	○	○
Metal implants near the treatment area or neutral electrode	○	○
Permanent implant near the treatment area	○	○
Pacemaker or internal defibrillator, or any other active electrical implant anywhere in the body	○	○
Current condition or history of skin cancer or current condition of any other type of cancer, or pre-malignant moles	○	○
History of any type of malignant cancer	○	○
Active collagen diseases	○	○
Cardiovascular diseases (such as vascular diseases, peripheral arterial disease, thrombophlebitis and thrombosis)	○	○
Pregnancy/nursing or IVF procedure	○	○
History of bleeding coagulopathies, use of anticoagulants	○	○
Any active condition in the treatment area, such as eczema, rash, rosacea, etc.	○	○
Any surgical procedure in the treatment area within the last 3 months or before complete healing	○	○
Poorly controlled endocrine disorders, such as diabetes	○	○
Tuberculosis	○	○
Hepatitis	○	○
Febrile conditions	○	○
History of skin disorders, keloids, very dry and fragile skin	○	○

Excessively tanned skin from sun, tanning beds or tanning creams within the last two weeks	○	○
Use of non-steroidal anti-inflammatory drugs one week before and after each treatment session	○	○
Treatment cannot be performed over tattoo or permanent make-up	○	○
Neurotoxin/collagen/fat injections or other injected bio-material in the treated area within three months prior to the treatment	○	○

If you answered YES to any of these questions, please specify:

* For the full range of contraindications, warnings, and caution, consult your treatment provider

Treatment Considerations

I am aware that pregnancy and nursing are contraindicated, and pregnant women can't undergo the treatment.

Initials:_____

I understand that there are certain side effects associated with EXION Fractional RF applicator treatments. These side effects may include but are not limited to intense heating sensation, pain, bleeding at contact locations, erythema, edema, itching and irritation, discomfort/sensitivity to firm tissue palpation, pigmentation change including hypopigmentation, hyperpigmentation, and post-inflammatory hyperpigmentation, temporary visibility of small crusts, blisters or burns.*

Initials:_____

I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely, but it is possible that I will not see any recognizable result after the procedure. Completing a full treatment series is recommended to maximize treatment efficacy. I acknowledge the results may not meet my expectations.

Initials:_____

I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions, and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects.

Initials:_____

I have read the above information, and I request and give my consent to be treated with the EXION Fractional RF by the physician(s) in the below-stated practice and his/her designated staff.

Initials:_____

My signature below indicates that the above information is accurate and current.

Patient's signature: _____ Date: _____

Witness (in print): _____ Signature: _____ Date: _____

Practice name: _____

EXION™ Fractional RF

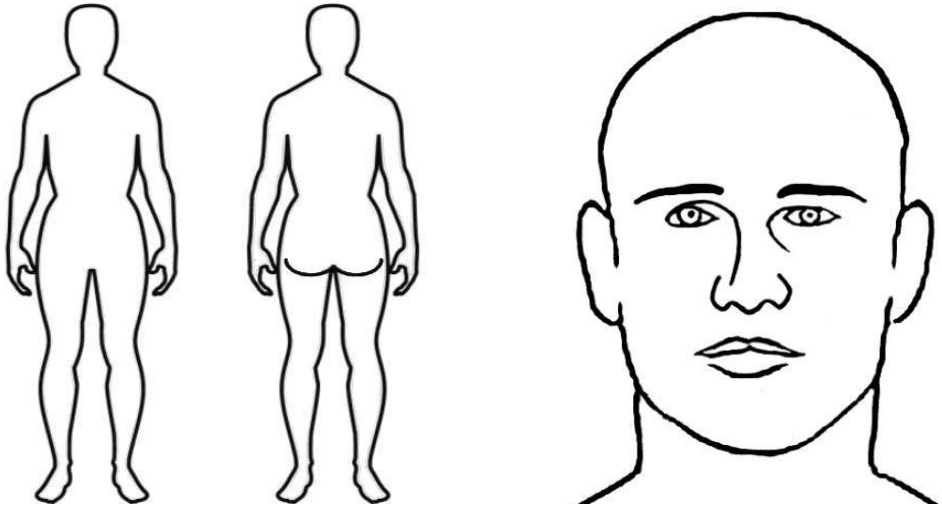
TREATMENT RECORD

Patient´s name or ID: _____

Treatment area(s) - describe or mark on the picture:

_____

_____



Age:_____

Skin Type:_____

Used tip: ○ Insulated ○ Non-insulated

SESSION #	DATE	NEEDLE DEPTH (mm)	EXTENDED MODE	ENERGY	DISPOSABLE TIP LOT NUMBER	PHOTOS	OPERATOR INITIALS
			ON / OFF			YES / NO	
			ON / OFF			YES / NO	
			ON / OFF			YES / NO	
			ON / OFF			YES / NO	

			ON / OFF			**YES / NO**	
			ON / OFF			**YES / NO**	