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DERMATOLOGIST
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Consent for Medical / Aesthetic Procedures

Full Name _____ Date _____

I voluntarily consent to and authorize Dr LM Nteta Dermatologist and associated aestheticians to treat my condition with this procedure(s):

- Chemical peel
- Microneedling
- Platelet rich plasma
- Medi-Facial
- Comedone-Extraction
- Skin tag or Warts removal

- ❖ I understand the treatment may involve risks of complications which include **Redness, irritation, swelling, tenderness, bruising and skin discoloration**. Due to the nature of the treatment exact results cannot be guaranteed.
- ❖ I agree to allow photographs of the intended procedure site for diagnostic purposes and to enhance my medical record to follow progression of my treatment.
- ❖ I understand that my responsibility is to follow the post-procedure care instructions and to maintain regular office visits that are critical to the success of the procedure.
- ❖ I acknowledge that I have been explained in terms clear to me and the nature of the procedure(s) and complications.

I confirm that I read and understood the above.

I hereby give my unrestricted informed consent for the procedure.

Dr LM Nteta Dermatologist.

Patient Signature: _____ Date: _____

Aesthetician Signature: _____ Date: _____