GOLD MICROINFUSION FACIAL Patient Instructions

Pre-Treatment:

- Inform provider of all medical conditions, medications you are taking, skin disorders, allergies, history of anaphylaxis, and any other medical problems you may have
- Avoid waxing and/or use of chemical depilatories on area to be treated 2 weeks **before** and **after** treatment
- Avoid any type of Chemical Peel on area to be treated for two weeks **before** and **after** treatment
- Avoid Retin-A, Renova and Tazorac for 7 days before appointment
- Avoid sun exposure and/or usage of a tanning bed, including self-tanning products for a minimum of 1 week before treatment. GOLD MICROINFUSION FACIAL will not be administered on sunburned skin
- Come to your appointment with **no makeup,** area must be clean and free of any products including sunscreen and lotion
- If you have a history of cold sore, we may recommend prophylactic antiviral therapy prior to treatment
- Do not stop taking any medications that have been prescribed to you without consulting your prescribing physician

Post-Treatment:

- **Do** contact me if you experience any problems or have any questions
- **Do** wait 6 hours post treatment before cleansing the face (with a gentle cleanser)
- **Do** sleep on your back with your head elevated slightly to reduce any swelling
- **Do** use a physical sunscreen of at least SPF 30 at all times, avoid direct sun exposure for at least 2 weeks
- **Do Not** participate in any strenuous exercise that causes sweating, sauna or steam rooms for 1 week
- **Do Not** use exfoliating skin care products or medications, or active chemical acids for at least 2 weeks

Other important information:

- Patient should be in good overall health
- **Do Not** use GOLD MICROINFUSION FACIAL if you are pregnant/breastfeeding or allergic to any of the ingredients
- Active skin infections are a contraindication to treatment
- GOLD MICROINFUSION FACIAL treatment will not be performed if you are under the age of 18
- For best results and efficacy, we recommend maintenance treatments every 3-4 months

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Patient Signature Patient Name (Print) Date

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Health Care Professional Signature Health Care Professional Name (Print) Date