



A&WMC
LICHEN TREATMENT

Name: _____ Date: _____
(First) (Last)
Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Alternative Phone: _____
Email Address: _____

Gynecological History

Last PAP (normal/abnormal)?: _____
If abnormal, specify and any treatment (Colpo, LEEP): _____
Last menstrual period?: _____

Medical History

Any diseases stimulated by heat?(ex: Herpes, Simplex): Yes() | No(): _____
Any skin disorders?: Yes() | No(): _____
Surgical procedures: _____
List of medications: _____
Allergies: _____
Detail any other medical condition: _____



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LICHEN TREATMENT WITH PLASMA CONSENT FOR PROCEDURE

I give my informed and voluntary consent and I authorize Dr. Angelica Hernandez and staff of Adolescent & Women Medical Care to administer platelet-rich plasma for the treatment of Lichen.

I understand that the procedure consists of injecting with very small needles, platelet-rich plasma into the areas of the genitals affected by this disease.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to taking before and after photographs.

I consent to the administration of topical anesthetics.

Smokers have less positive response to this treatment than non-smokers, since the toxins in cigarette smoke block the response of the stem cells. There may be some variation in achieving the results requested as everyone's body type is different and may have a different response.

I fully agree to hold Adolescent & Women Medical Care, Dr. Angelica Hernandez and any and all parties affiliated with her, harmless and free from any liability that may arise as a result of this treatment both now and in the future. I certify that I have been given the opportunity to ask questions and that I have read and fully understand the content of this consent form.

Patient Name: _____

Signature: _____

Date: _____