PERMANENT COSMETICS AND MAKEUP BY DONNA RAE

401 Olympia Ave NE #234
Renton, WA 98056
425.870.3448

Pre-Treatment Advice

1) Since delicate skin or sensitive areas may swell slightly, or redden, it is advised not to make social plans for the same day. Lip liner may appear "crusty" for up to one week.

2) Please wear your normal make-up to the procedure. If you are having lips or brows done, please bring your favorite pencils.

3) If unwanted hair is normally removed in the area to be treated, i.e.; tweezing or waxing, the hair removal should be done at least 24 hours prior to your procedure. Electrolysis should not be done within five days of the procedure. Do not resume any method of hair removal for a week after the procedure.

4) If eyelashes or eyebrows are normally dyed, do not have that procedure done within 48 hours of this procedure. Wait one week after the eyebrow or eyeliner procedure before dying lashes or brows.

5) If you wear contact lenses and are having the eyeliner done, do not wear your lenses to your appointment and do not replace them until the day after the procedure.

6) If you are having the eyeliner procedure done, as a safety precaution, in case of watering or swelling, we recommend that you have someone available, or accompany you, who could drive you home if you so decide, or if it is necessary.

7) If you are having lip liner done and have had previous problems with cold sores, fever blisters, or mouth ulcers, the procedure is likely to re-activate the problem. Your Intradermal Cosmetic Technician can make recommendations to help prevent or minimize the outbreak.

8) We recommend allergy testing of pigment before the planned procedure.

9) Do not use aspirin or ibuprofen for 7-days prior to your procedure.

10) Please arrive, with only eyebrow makeup (i.e. pencil) as you would wear on a day to day basis to determine the desired color and shape, no face makeup needed, as I will be cleaning pigment during application.

11) You may want to bring your makeup bag to do touch-ups before you leave if needed.

We look forward to working with you. If you have any questions, please call or make notes so we can discuss them with you when you arrive for your appointment.

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CLIENT COPY – Post Procedure

FOR ALL PROCEDURES
(Eyebrows, Eyeliners, Lip Liner / Full Lips, Areola, and Scar Camouflage)
Immediately Following Cosmetic Tattoo Procedure:
Apply ice to treated area for 10 - 30 minutes. Ice helps reduce swelling and aids in healing.

For 14 days following application of permanent cosmetics:

* Apply antibiotic ointment sparingly twice a day for two days following the procedure, using a clean cotton swab; not your fingertips. Use Petroleum Jelly until Healed (at least 10 days). **Antibiotic ointment and petroleum jelly will be provided.**
* Do not rub or pick at the epithelial crust; allow it to flake off on its own. There should be absolutely no scrubbing, no cleansing creams or chemicals. Gently cleanse the intradermal cosmetic area with a mild antibacterial soap. You may rinse with water and lightly pat the area dry. Do not expose treated area to full pressure of the water in the shower.
* Do not soak treated area in bath, swimming pool or hot tub. Do not swim in fresh, salt or chlorinated pool water.
* Do not expose the treated area to the sun.
* Use a total sun block after the procedure area has healed to prevent future fading of pigment color.
* Do not use mascara or eyelash curler for seven days post procedure. When you resume use purchase a new tube, the old tube may have bacteria in it.
* If you are a blood donor you cannot give blood for 1 year following your procedure (per American Red Cross).
* Use sterile bandages and dressings when necessary. (Areola and Camouflage procedure cannot be guaranteed. This is an experimental procedure.)

I understand that at the first sign of an infection, adverse reaction or allergic reaction to the procedure, I must notify Donna Rae, Health care practitioner, and the Washington Department of Health, Drugs and Medical Devices Division.

Failure to follow post-treatment instructions may cause loss of pigment, discoloration or infection. Remember, colors appear brighter and more sharply defined immediately following the procedure. As the healing progresses, color will soften. A touch-up procedure may or may not be necessary. Final results cannot be determined until healing is complete. Touch-up procedures must be made between 30-60 days following the procedure. Additional fees will apply for touch-ups after 60 days following the procedure. If necessary, an appointment for a touch-up can be made.

IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CALL.

Enjoy your permanent cosmetics!

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Disclosure and Consent for Tattoo and Dermal Procedures

I, _____, as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure.

You have described the recommended procedure to be used as Micro Pigment Implantation, the process of implanting micro insertions of pigment into the dermal layer of skin. Micro pigment Implantation is a form of tattooing used for the purpose of permanent cosmetic makeup and skin imperfection camouflage.

I voluntarily request as my intradermal cosmetic technician, Donna Rae and such association and technical assistance as she may deem necessary to perform on my body the following procedure (circle one):

UPPER EYELID LOWER EYELID LOWER MUCOSAL EYELID EYEBROW FULL LIP COLOR LIPLINER
AREOLAS SCAR CAMOUFLAGE STRETCH MARKS OTHER:_____

Please Initial:

_____ I hereby authorize Donna Rae to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of advertising.

_____I hereby authorize Donna Rae to take photographs of the work performed both before and after treatment to be maintained only in file.

_____I have informed Donna Rae that I am in good health and not under the care of any physician.

_____I am currently under the care of a physician and I am being treated for the following condition(s):

_____

Physician's Name:_____ Phone Number:_____
Address:_____ City/State:_____ Zip:_____

Please Initial:

_____I understand that this description of the procedure is not meant to scare or alarm me. It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure.

_____I have been told that there may be known and unknown risks and hazards related to the performance of the procedure planned for me and I understand that no warranty or guarantees have been made to me as to the results.

_____I acknowledge the manufacturer of the pigment to be applied requires spot testing and specifically disclaims any responsibility for any adverse reaction to applied pigments. I understand spot testing may identify individuals who develop an immediate allergic reaction to pigment;

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Disclosure and Consent for Tattoo and Dermal Procedures (continued)…

however, spot testing does not identify individuals who may have a delayed allergic reaction to pigment. I agree to (circle one):

RECEIVE WAIVE a spot test prior to application and I agree to release Donna Rae, assistants and pigment manufacturer(s) from any and all liability related to allergic reaction or any other reaction to applied pigments.

_____I have been told that allergic reactions to pigment are very rare, however, they can and do occur and when they occur they can be serious and especially difficult and very troublesome to treat.

_____I have been told that this procedure will involve pain and discomfort.

_____I understand the markings are permanent and that there is a possibility of hyper pigmentation resulting from a procedure, especially in individuals prone to hyper pigmentation from a scar or other injury.

_____I have been told that a follow up procedure may be required.

_____I have been told that there is a chance that I may experience a corneal abrasion.

_____Other risks involved with the procedure may include, but not limited to: infections, allergic and other reaction(s) to applied pigments, allergic and other reaction(s) to products applied during and after the procedure, fanning or spreading of pigment (pigment migration), fading of color and other unknown risks.

_____I accept full responsibility for any and all, present and future, medical treatment(s) and expenses I may incur in the event I need to seek treatment(s) for any known or unknown reason associated with the procedure planned for me.

_____I have been given an opportunity to ask questions about the procedures and the procedure to be used and the risks and hazards involved and I believe that I have sufficient information to give this informed consent.

_____I have agreed that should I have a complaint of any kind whatsoever, I shall immediately notify Donna Rae and I further agree that any controversy or claim arising out of or relating to this consent and/or any signed contract between myself and Donna Rae or the breach thereof, shall be settled by arbitration in the state of Washington in accordance with the Rules of the American Arbitration Association and judgment of the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

_____I understand that if I have an infection, adverse reaction or allergic reaction to the procedure, I must notify Donna Rae, a health care practitioner, Washington Department of Health, Drugs and Medical Devices Division.

_____I certify this form has been fully explained to me and I have read it or it has been read to me. I understand its contents.

_____I have received a copy of the Post Procedure Instructions. It has been fully explained to me and I have read it or it has been read to me. I understand its contents.

_____ _____

Signature Date

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Medical History Form

Today's Date: _____/_____/_____ Birth date:_____/_____/_____

Name:_____

Home Address:_____

No. & Street City State Zip

Work Address:_____

No. & Street City State Zip

Home Phone:(_____)_____ Work Phone:

_____(_____)_____

Employer:_____ Occupation:_____

Are you now or have you been under the care of a physician within the last two years?_____

If yes, please provide Physician's Name, address and phone number._____

_____

Person to contact in an emergency:_____

Name

_____

Address & Phone No.

List all medications you are currently taking, including Retin A, Glycolic Acid and Acutane:

_____

List any drug, makeup, skin or food allergies (i.e., soaps or cleansing creams):_____

Have you recently undergone a skin peel?_____

What products do you use for skin care?_____

Do you have or have you had any of the following conditions (answer Yes or No):

_____ Abnormal Heart Condition
_____ Cold Sores
_____ Herpes Simplex
_____ Hemophilia
_____ High or Low Blood Pressure
_____ Prolonged Bleeding
_____ Circulatory Problems
_____ Epilepsy
_____ Diabetes
_____ Fainting Spells/Dizziness
_____ Cataracts
_____ Glaucoma
_____ "Dry Eye"
_____ Corneal Abrasions
_____ Eye Surgery or Injury
_____ Blepharoplasty (eyelid surgery)
_____ Visual Disturbances
_____ Cancer
_____ Tumors/Growths/Cysts
_____ Chemotherapy/Radiation
_____ Are you pregnant?
_____ Hepatitis
_____ Do you wear contact lenses?
_____ Do you use tobacco products?
_____ Are you using any eye drops or other ocular medications?
_____ Have you ever experienced hyper-pigmentation from an injury?
_____ Are you currently taking aspirin or ibuprofen?

When was your last eye exam? ____/____/____

Examining Physician: _____

_____ _____

Signature Date

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Post Procedure Instructions

FOR ALL PROCEDURES
(Eyebrows, Eyeliners, Lip Liner/Full Lips, Areola, and Camouflage)
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* Do not rub or pick at the epithelial crust; allow it to flake off on its own. There should be absolutely no scrubbing, no cleansing creams or chemicals. Gently cleanse the intradermal cosmetic area with a mild antibacterial soap. You may rinse with water and lightly pat the area dry. Do not expose treated area to full pressure of the water in the shower.
* Do not soak treated area in bath, swimming pool or hot tub. Do not swim in fresh, salt or chlorinated pool water.
* Do not expose the treated area to the sun.
* Use a total sun block after the procedure area has healed to prevent future fading of pigment color.
* Do not use mascara or eyelash curler for seven days post procedure. When you resume use, purchase a new tube, the old tube may have bacteria in it.
* You cannot give blood for 1 year following your procedure (per American Red Cross).
* Use sterile bandages and dressings when necessary. (Areola and Camouflage procedure cannot be guaranteed. These are an experimental procedures.)

I understand that at the first sign of an infection, adverse reaction or allergic reaction to the procedure, I must notify Donna Rae, a health care practitioner and the Washington Department of Health, Drugs and Medical Devices Division (360)236-2828.
Failure to follow post-treatment instructions may cause loss of pigment, discoloration or infection. Remember, colors appear brighter and more sharply defined immediately following the procedure. As the healing progresses, color will soften. A touch-up procedure may or may not be necessary. Final results cannot be determined until healing is complete. Touch-up procedures must be made between 30-60 days following the procedure. Additional fees will apply for touch-ups after 60 days following the procedure. If necessary, an appointment for a touch-up can be made..

PLEASE FEEL FREE TO CALL IF YOU HAVE ANY FURTHER QUESTIONS.

Enjoy your permanent cosmetics!

_____
Signature

****TO BE COMPLETED BY TECHNICIAN****
Photocopy Driver's License Here
Or Record Necessary Information

Name:_____
_____
_____
License Number:_____
_____

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Date:

Name:

Address:

City : ST: Zip:

Home Phone: Work Phone:

Referred By:

Fees Discussed:

Procedure Request:

Areas of Concern:

Technician Name:

Pigment(s) Used:

Lot # & Batch #:

Expirations Date:

Machine(s)Needle(s) Used:

Anesthetic Used:

Touch-up(s) Done On:

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Infection, Adverse Reaction, Allergic Reaction Incident Report

To Be Forwarded Within 5 Days of Incident to

Washington Department of Health

Drugs and Medical Devices Division
(360) 236-2828

Date Reported: _____/_____/_____	Date of Procedure: _____/_____/_____
Date Mailed to WA Department of Health: _____/_____/_____	
Client Name:	Address:
Work Phone:	City:
Home Phone:	State & Zip:
Color(s) Used:	
Description of problem:	
Attending Physician:	
Address:	
Phone:	