Dr. Peter Bray – Certified Plastic Surgeon, MD, MSc, FRCS (C)
Phone: (416) 323-1330 | Fax: (416) 323 – 9397 | info@drbrayplasticsurgery.com | www.drbray.ca
66 Avenue Rd., Upper level, Toronto, ON M5R 3N8
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Fractora Consent

Medical History:

Please inform Dr. Bray'sstaff priorto treatment if you have any of the following conditions that may make you unsuitable for the Fractora treatment

- Pregnancy or nursing
- Under 18 years of age
- Pacemaker or internal defibrillator
- Permanent implant in the treated area such as metal plates and screws, silicone implants r an injected chemical substance
- Current or history, of cancer, especially skin cancer, or pre-malignant moles
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use other immunosuppressive medications
- Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kinder diseases
- A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment are excessive/freshly tanned skin
- History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry ahd fragile skin
- Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction
- Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing
- Superficial injection of biological fillers in the last 4 weeks or Botox in the last 2 weeks
- Use of Isotretinoin (Accutane) within 6 months prior to treatment
- Lidocaine allergy
- Autoimmune disorder

Informed Consent:

This form is designed to give you the information you require to make an informed choice whether undergo treatment with Fractora technology. If you have any questions before your treatment, please ask your provider.

- I authorize Dr. Bray's staff to perform the Fractora procedure
- They have received my medical history
    - I have received the following information about the technology
    - Fractora technology utilizes fractional radiofrequency indicated for facial/neck/chest and back of hands, as well as small body areas

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  - Fractora treatment induces ablation, thus improving the appearance of rough texture, fine lines, wrinkles, and depressed scars, such as acne scars along with superficial pigments that will be ablated.
  - The treatment also induces skin rejuvenation by heating the dermis, which stimulates collagen generation and replenishment, as well as closure of superficial fine blood capillaries.
  - The treatment requires a topical anesthetic cream.
- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- I was told about the possible side effects of the treatment including: local pain, skin redness, swelling, damage to the natural skin texture (crust, blisters, burn), change of skin pigmentation (hyper or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, redness and swelling may last up to 3 weeks, and are part of a normal reaction to the treatment. Burns resulting in pigmentation change and scarring are rare and may happen in areas of dark skin. Tiny scabs appear on the face for a few days as part of a normal healing, however make-up maybe applied as soon as 1-3 days after the session to mask them and residual redness. Any adverse reaction should be reported immediately.
- I understand that the treatment involves a few sessions (3-6), a few weeks apart (3-6), according to treatment parameters and individual response.
- I understand that I must comply with treatment schedule, otherwise results may be compromised.
- I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.

1. I have had sufficient opportunity to discuss my conditions and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. My questions have been answered to my satisfaction.
3. Authorize before, during and after the procedure (s) the taking of photographs to b part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity.

Patient Signature: _____ Date: _____

Healthcare Provider: _____ Date: _____