

Microsclerotherapy Prescription Form

Client Reference No: _____

Name: _____

Address: _____

_____ Contact No: _____

Client requesting treatment

I confirm I have understood and answered the questions regarding my medical history honestly and that this information is correct to the best of my knowledge

I also confirm that the procedure of compression microsclerotherapy has been explained to me and I have had an opportunity to ask any questions and had them answered to my satisfaction. I have read and signed the consultation sheet.

I have been advised regarding after care and have been given the written aftercare sheet. I have understood and agree to follow these instructions.

I request compression microsclerotherapy and have read and signed the consent form.

Signed

*Medical Supervisor

I have read the medical history for

and am satisfied that compression microsclerotherapy is appropriate and safe for this client.

Authorised for treatment from: date(valid for one year)

Treatment is to be administered by

Signed(name of authorising doctor)

Prescription

Date	Drug	Drug % strength	Volume/treatment session	Signed

Notes:

* please note: Only drugs licensed for microsclerotherapy can be prescribed, unless the client is examined and consented by the prescribing doctor.