DONOVAN
HAIR RESTORATION

CONSENT FOR DPCP or SQUARIC ACID OUTPATIENT APPLICATION (SCALP CHEMICAL SENSITIZIATION TREATMENT)

1.I, _____ _____(please write name) hereby agree to undertake "scalp chemical sensitization treatment" at home as an outpatient. I am responsible for applying the treatment at home (or having someone apply it). I am responsible for my safety or the safety of the person who applies it. If I feel unable to do so, I will not begin treatment or will stop.

2.I understand that scalp chemical sensitization treatments do not help everyone, but help approximately 50-70 % of patients with patchy alopecia areata and 20 % of patients with alopecia totalis and fewer with alopecia universalis. I understand that it is a common treatment around the world but there are no formally FDA approved treatments for alopecia areata.

3. I agree to STOP treatment immediately if Dr Donovan feels I can not safely use this treatment as an outpatient. If Dr Donovan says STOP I agree to STOP this treatment.

4. An explanation of the procedure has been given to me. I understand that I will first apply the 2 % dose to a coin shaped area and then wash it out 48 hours later. I understand in many cases Dr Donovan will perform this in the clinic rather than have me do the first treatment.

5. I understand I will then wait 2 weeks before starting the next treatment. This will be with the 0.001% dose to the areas of hair loss.

6.I understand that the person who is applying the medication must wear gloves at all times as this will cause an allergic reaction in the person applying it if the medicine touches the skin. I understand that the person applying the medication is at risk for an allergic reaction.

7. I understand that should I ever develop a very itchy unbearable area of itching or blistering that I will apply the steroid cream prescribed and contact Dr Donovan.

8.I am aware of the pros, cons and alternatives to scalp chemical sensitization treatment. I understand there are steroid injections and immunosuppressive pills that can be used. I understand I have the option of not doing any treatment or wearing a wig.

9. I understand that female patients must not get pregnant will using this treatment.

10. I understand that family friends and others must not touch my scalp while this treatment is on my scalp. They would develop an allergic reaction should they do so.

11. I understand that hair may grow back with scalp chemical sensitization treatment and that it is possible that hair is lost again weeks, months or years later. I understand that the scalp chemical sensitization treatment may work well the second time or third time or fourth time etc it is used - but not always

I understand the side effects of scalp chemical sensitization treatment:

PLEASE INITIAL NEXT TO EACH OF THE FOLLOWING:

_____ Rash on the scalp – (this is expected)

_____ Itching of the scalp – (this is expected)

_____ Scaling of the scalp – (this is expected)

_____Swollen lymph nodes on the neck – expected & not serious

_____ Full body rash (even if the treatment does not touch the area)

_____ Blisters on the scalp or body

_____ Pigmentation changes on the scalp – some areas lighter and some areas darker

_____ Fever

I have read and understand all of the possible side effects and complications listed above. I accept the risks of these possible complications and consequences associated with this procedure

_____ _____

Patient Signature Date Physician Signature Date

10. I consent to treatment with scalp chemical sensitization treatment

11. I consent to having my photos taken. These include pre-procedure ('before') photos, photos during the procedure ('during') and post-operative ('after') photos. I understand these photos will not reveal my identity. I give consent to Dr. Donovan and Dr. Jeff Donovan Medicine Professional Corporation to use these photos in teaching and research, including teaching of doctors, students, trainees and the general public. I consent to having photos used for advertising purposes, which may include brochures, websites and use during pre-operative consultations. I understand that I may withdraw consent by stating 'no consent for sharing photos' on line 19 below. However, photos will still be obtained for my chart and for purposes of documentation of treatment outcomes.

12. I believe that I have been well informed. I understand that good results are expected, but the practices of medicine and surgery are not exact sciences. I understand that knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

13. I understand that the success of the scalp chemical sensitization treatment is dependent on my closely following all instructions

14. I understand how to contact Dr. Donovan should I have any concerns and understand that I have been given his emergency contact number which I can use at any time 24 hours per day, 7 days per week.

15. I understand that if I am having what appears to be a serious reaction that I will not rely on the above contacts for Dr. Donovan or his office. If I am having a serious reaction such as swelling of the lips or tongue or shortness of breath or rapidly spreading rash that I will call 911 or go to my nearest emergency room of the nearest hospital of evaluation. I do understand that serious side effects are very rare.

16. Even though scalp chemical sensitization treatment is an 'outpatient' procedure, I agree to come into the clinic at any time Dr Donovan advises me to.

17. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents. I was given the opportunity to ask questions about scalp chemical sensitization treatment.

18. I have disclosed all information regarding past and present medical conditions, current medications and known drug allergies.

19. I certify that no one has made any guarantee or warranty as to the final outcome or appearance that may be expected.

20. I have been given the opportunity by my physician to ask questions and all of my questions have been answered to my satisfaction. I impose the following limitations on my treatment:

_____

_____

DATE: _____

TIME: _____ (am or pm)

I have read the above information and am aware of the risks, benefits and alternatives of scalp chemical sensitization treatment. I have been provided with the opportunity to have questions answered and therefor give my consent to participate in scalp chemical sensitization treatment for my hair loss.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Doctor **Date**