# BTL EXILIS SYSTEM

## GENERAL PATIENT RECORD – ROD J TURNER MD

| Patient's name: | Date of birth: | Age: |
|---|---|---|
| Phone: | Email: | |

You are scheduled for a series of non-invasive treatments with the BTL Exilis System. The device is intended for use in non-invasive dermatological procedures.

The BTL Exilis System is a radiofrequency (RF) device that delivers high energy in a controlled fashion to the dermal and subcutaneous layers of the skin. **Initials:** _____

Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 2-4, with sessions separated by 7-14 days. You may need additional treatments depending on the severity of your condition. For optimal results, it is important to follow the treatment plan that has been established for you. The results will typically continue to improve over the next 3 months after last session. **Initials:** _____

There is typically no pain associated with your treatment and there is no anesthetic required. You will experience very intense heating sensation during or just following the treatment. The procedure doesn't require any recovery time. Typically, you can get back to your daily routine right after the treatment. **Initials:** _____

The area of interest must be free from hair and there must be no make-up or creams/lotions on the skin. I acknowledge I have been advised to shave the area prior to procedure or the area will be shaved at the procedure visit. **Initials:** _____

If the treatment area is on your body (doesn't apply to facial or vaginal/vulvar treatments), please arrive at your appointment well hydrated. Ideally, you should hydrate 2 days before and on the day of the treatment as this will result in a more comfortable and efficacious treatment. **Initials:** _____

On the day of the treatment you are advised to wear comfortable clothing so the treatment area can be easily accessed. You will be asked to remove any jewelry from the area of interest. **Initials:** _____

I acknowledge that successful treatment outcome can be affected by smoking or excessive alcohol consumption, same as by eating disorders, on-going medication or insufficient hydration. While no special diet is required, you are encouraged to eat healthy to help promote and maintain results. **Initials:** _____

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**Please answer whether you currently have or have had any of the following:**

- Bacterial or viral infection, acute inflammations, febrile conditions ☐ YES ☐ NO
- Impaired immune system ☐ YES ☐ NO
- Isotretinoin in the past 12 months ☐ YES ☐ NO
- Cancer, Radiation therapy ☐ YES ☐ NO
- Burns, sensitivity disorders or poor healing in the treatment area ☐ YES ☐ NO
- Metal implants ☐ YES ☐ NO
- Implantable pacemaker or automatic defibrillator / cardioverter ☐ YES ☐ NO
- Intrauterine device ☐ YES ☐ NO
- Ablative / non-ablative cosmetic intervention (deep peeling) in the past 3 months ☐ YES ☐ NO
- Active collagen diseases, Sclerodema ☐ YES ☐ NO
- Cardiovascular diseases, Varicose veins ☐ YES ☐ NO
- IVF procedure ☐ YES ☐ NO
- Acute neuralgia and neuropathy ☐ YES ☐ NO
- Blood disorders, risk of bleeding, bleeding tissues, peptic ulcers ☐ YES ☐ NO
- Eczema or Rosacea ☐ YES ☐ NO
- Kidney or liver failure ☐ YES ☐ NO
- Pronounced edemas, ascites, exudates ☐ YES ☐ NO
- Tuberculosis ☐ YES ☐ NO
- Sexually transmitted infection ☐ YES ☐ NO

**If you answer YES to any of these questions, please specify:**

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For the full range of contraindications, warnings and cautions, consult your treatment provider.

- I am aware that pregnancy and nursing are contraindicated and pregnant women can't undergo the treatment. **Initials: ______**
- I am aware that I can't undergo vaginal or vulvar treatment when menstruating or during postpartum period. **Initials: ______**
- I understand that there are certain risks associated with BTL Exilis System treatments and they include but are not limited to: erythema, very intense heating sensation or mild pain and dry skin.* I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials: ______**
- I agree to before and after treatment photographs, measurements and weighting, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials: ______**
- I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. **Initials: ______**
- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects. **Initials: ______**
- I have read the above information, and I request and give my consent to be treated with the BTL Exilis System by the physician(s) in the below stated practice and his/her designated staff.

My signature below indicates that the above information is accurate and current.

**Patient signature:** ____________________________________________ **Date:** ________________

**Witness (in print):**____________________________**Signature:** _________________________ **Date:** ________________

**Practice Name:** ________ROD J TURNER MD PA___________________

*For the full range of possible adverse effects and expected device-related treatment sequelae, consult your treatment provider.

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# BTL EXILIS SYSTEM

## SAMPLE TREATMENT RECORD – ROD J TURNER MD PA

**Patient's name or ID:** ______________________

Photos taken: YES / NO

**Treatment area(s) -** describe or mark on diagram:

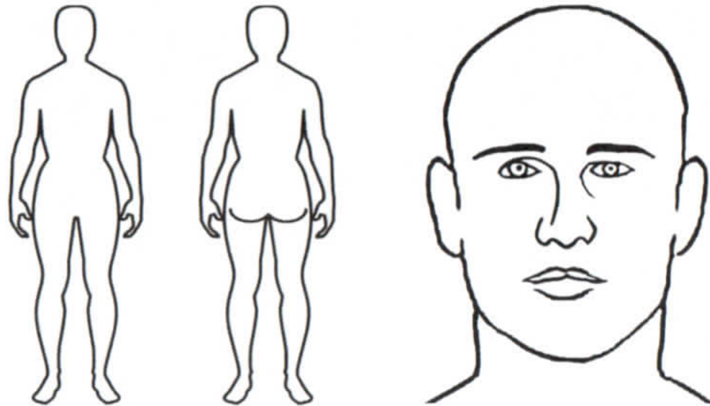
______________________

**For Intimate treatments:**

| | | | |
|---|---|---|---|
| Vaginal Canal | YES / NO | Introitus | YES / NO |
| Mons pubis | YES / NO | Perineum | YES / NO |
| Labium Majus left | YES / NO | Labium Majus right | YES / NO |

**Applicator:** ☐ Large ☐ Small  **Tip:** ☐ F-tip ☐ V 30 ☐ V 24 ☐ V-tip

**Weight before 1st Tx/after last Tx:** _______/_______



| SESSION # | DATE | TREATMENT TIME | POWER RANGE | COOLING / DUTY FACTOR | ELECTRODE PLACEMENT | HEAT SENSATION* | COMMENTS | OPERATOR INITIALS |
|---|---|---|---|---|---|---|---|---|
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* On a scale of 0-10 with 0 being no perception of heat and 10 being intolerable heat

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