



Vanquish Patient Instructions

- 1) I understand that completing a full series (6 treatments), administered 7-14 days apart, is necessary to maximize treatment efficacy.
- 2) I understand there are certain risks associated with BTL Vanquish ME treatment and they include but are not limited to:
 - Burn due to excessive exposure, reduced thermal sensation, hypersensitive skin, impaired blood flow, moisture in the treatment areas.
 - Heat injury to the tissue surrounding a metal-containing IUD
 - Increased menstrual flow in female patients receiving treatment to the lower back or pelvis.
 - Erythema
- 3) I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks.
- 4) I confirm that I do not have the following conditions:
 - Electronic implanted devices Patients with electronic implanted devices should NEVER be treated with Vanquish ME (e.g. cardiac defibrillator, pacemaker, insulin pump, and cochlear implant). Keep in mind that even if the active implant has been removed, the metal leads may still remain.
 - Metal implants Patients with metal implants in the treated area should not be treated.
 - Visceral fat Visceral fat located deep in the abdominal cavity under the muscle cannot be treated. Not enough energy penetrates deep enough.
 - Pregnant/nursing
 - Cancer
- 5) I confirm that I do not have an inserted pacemaker, internal defibrillator, or any other active or inactive metal implants. I am not pregnant or breastfeeding.
- 6) I have been advised to increase my water intake at least 48 hours before and after treatment
- 7) I agree to before and after treatment photographs, measurements, and weight as this will help in the evaluation of the results of the treatment.
- 8) 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.

Patient Name _____

Patient Signature _____ Date _____