CRYOREFRESH
RECOVERY | HEALTH | WELLBEING

Professional Sports Recovery (PSR) Compression Therapy Consent Form

PATIENT DETAILS:

Name:______________________ Date of Birth: _________________ Contact Number: __________________

Address:

E-mail Address: _______________________________

Are you taking any medication? (Y/N) _______

If yes, please state: ____

Emergency Contact Details: Name: __________________ Relationship: __________ Contact number: _____________

Please read the information below CAREFULLY. If you suffer from any of the contraindications listed below it is advised that you DO NOT PARTICIPATE IN ANY Cryostimulation treatments. From the list of absolute contraindications to Cryostimulation below, tick the boxes that currently apply to you:

Condition	Yes	No	Condition	Yes	No
➢ Fresh Myocardial Infarction	☐	☐	➢ Severe, untreated high blood pressure	☐	☐
➢ Pulmonary edema	☐	☐	➢ Acute soft tissue trauma of the limbs	☐	☐
➢ Cardiac and Renal Edema	☐	☐	➢ Neuropathy	☐	☐
➢ Decompensated Cardiac Insufficiency	☐	☐	➢ Occluding processes in the lymphatic stream area	☐	☐
➢ Erysipelas	☐	☐	➢ Extensive thrombophlebitis, thrombosis or suspected thrombosis	☐	☐

I confirm that to the best of my knowledge, the answers I have given are correct and I have not withheld any information that may be relevant to my treatment. I certify that the proceeding medical and personal history statements are true and correct. I am aware that it is my responsibility to inform my therapist of my current medical or health conditions and to update this history, as a current medical history, is essential to execute appropriate treatment procedures.

Due to PSR Compression therapy being contraindicated under certain conditions, I confirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and I understand there shall be no liability on the therapist's part should I forget to do so.

I understand I may be asked to remove clothes as part of the treatment (not underwear). I am signing this consent form to ensure my dignity is held in high regard at all times by the professional. I understand I will be offered towels and robes at the start of the treatment (if required).

I am happy to proceed with the process that I am entering into and I do so at my own risk. By signing the consent form I agree that I have read and understood the contraindications to PSR Compression Therapy treatments. The risks of the treatment have been explained to me and I have had an opportunity to discuss and clarify any concerns with the trained personnel. The signature below confirms my consent to undergo PSR Compression Therapy treatment.

DATE & SIGNED

Dated: _________________ Cryotherapy technician Name: ___________________

Client Signature: __________________ Cytotechnician Signature: __________________