VALLEY EYECARE CENTER

Patient Name: _____ Date:_____

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

Initials

- I authorize Doctor _____ to perform IPL™ treatments on me in an effort to improve Dry Eye / Hyperpigmentation /Haemangioma / Angioma / Rosacea / Telangiectasia. _____
  Other: _____
- I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility _____
- I understand the below list of short-term effects and agree to follow matching guidelines:
  - Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring
  - Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams _____
  - Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or inflammatory creams
  - Bruising may rarely occur and may last up to 2 weeks
- I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications _____
- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered _____
- Pre and post-care instructions have been discussed and are completely clear to me _____
- I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required _____
- I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record _____
- I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity _____
- I agree to review the following IPL™/laser pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge _____

	Skin type of the area to be treated: I □ II □ III □ IV □ V □ VI □		
	Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan	NO	YES
	Use of self–tanners or tan enhancer caps within the past 3-4 weeks pre-op plan	NO	YES
	Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc…) or aromatherapy (essential oils)	NO	YES: .....
	Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria	NO	YES: .....
	Pregnant or possibility of pregnancy, postpartum or nursing	NO	YES
	Inflammatory skin conditions (dermatitis, active acne, etc...)	NO	YES: .....
HR	Presence or history of active cold sores or herpes simplex virus	NO	YES
PL	HIV	NO	YES
SR	Active cancer (currently on chemotherapy or radiation)	NO	YES
VL	Previous skin cancer?	NO	YES
	Medical history of keloids	NO	YES
	Intake of isotretinoin within the past year	NO	YES
	Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES: .....
	Any known allergy?	NO	YES: .....
	Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	NO	YES
	List of additional current medication taken		
HR	Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO	YES: .....
	Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…)	NO	YES: what/when? .....
PL	Any observed modification (colour, size, texture and border) on the lesion to be treated?	NO	YES: .....
SR	Any hair on requested treatment area that should not be removed?	NO	YES
VL	Age of lesion onset?		
PL	Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...)	NO	YES: what/when? .....
SR	Intake of aspirin or anti-coagulants?	NO	YES: .....
VL	Easy bruising?	NO	YES
	Swollen legs or pain after long standing/sitting?	NO	YES
VL	Previous vein surgery on requested treatment area (sclerotherapy, stripping, etc…)	NO	YES: what/when? .....

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to M22™ skin treatments

Name of patient (please print) Signature of patient Date

Name of witness (please print) Signature of witness Date

(1 copy Patient and 1 copy Physician for Medical Record)

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