*Dermatology Consultants of Marin*

*5000 Civic Center Drive*

*San Rafael, CA 94903*

*(415)499-0100 Office (415) 499-0290 Fax*

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

|  |  |
| --- | --- |
|  | Initials |
| * I authorize to perform IPL™ / Nd:YAG treatments on me   in an effort to improve Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia / Leg vein /  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 |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **HR PL SR VL** | 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: ……………….…………….. |
| Presence or history of active cold sores or herpes simplex virus | NO | YES |
| HIV | NO | YES |
| Active cancer (currently on chemotherapy or radiation) | NO | YES |
| 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 SR VL** | Any observed modification (colour, size, texture and border) on the lesion to be treated? | NO | YES: ……………….…………….. |
| Any hair on requested treatment area that should not be removed? | NO | YES |
| Age of lesion onset? |  | |
| **PL SR** | Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...) | NO | YES: what/when?  ……………….…………………………. |
| **SR VL** | Intake of aspirin or anti-coagulants? | NO | YES: ……………….…………….. |
| Easy bruising? | NO | YES |
| **VL** | Swollen legs or pain after long standing/sitting? | NO | YES |
| 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 |