IPL Skin Rejuvenation & Hair Removal
Clinical Treatment Forms

- **Medical History Form**
- **IPL Skin Rejuvenation Consent Form**
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- **Vascular/Pigmented Lesions Disclosure & Consent**
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Sample Medical History

Name_____
Address_____
Home Phone_____ Business Phone_____
Age_____ Referred by_____
Have you ever had the following?

- Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.
- Any active infection.
- Diseases which may be stimulated by broadband light, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- Use of photosensitive medication and/or herbs that may cause sensitivity to broadband light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.
- Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.
- Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
- History of bleeding coagulopathies, or use of anticoagulants
- History of keloid scarring.
- Very dry skin.
- Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment.

Are you pregnant?_____
What medications are you taking (including aspirin)?_____
_____
Daily consumption of alcohol_____
Allergies: _____
_____
Are you taking any herbal preparations? (St. John's Wort, etc.)_____
If yes, list _____
Do you wear contact lenses? _____

Skin type (when exposed to the sun **without protection** for about 1 hour)

- always burns, never tans_____
- always burns, sometimes tans_____
- sometimes burns, sometimes tans_____
- always tans_____
- Hispanic, Asian, Mediterranean, Middle Eastern_____
- Black_____

When were you last exposed to the sun (including tanning booth)?_____
Do you use chemical sun tanning lotions?_____
Are you In-service a holiday in the sun?_____

Reason for visit (area to be treated)_____
_____

Prior treatment (if any) _____

IPL Skin Rejuvenation Consent Form

Patient name _____

Treatment sites _____

I duly authorize _____ to perform the IPL Skin Rejuvenation procedure and any other measures which in their opinion may be necessary.

I understand that the IPL is an aesthetic device used for skin rejuvenation and that clinical results may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the IPL Skin Rejuvenation system involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature_____

Date_____

Witness_____

Hair Removal Consent Form

I hereby authorize _____ to perform laser hair reduction with the Hair Removal Laser on me.

I have been informed that Laser Hair Removal is a procedure by which hair from the body can be removed utilizing the Laser Technology. Laser hair removal involves matching laser light and pulse duration to the follicle size, depth and location to inhibit the re-growth of the removed hair. A technician will distribute the light of an Long Pulse Laser onto the skin to perform Laser Hair Removal. The laser works by disabling the hairs that are in their active cycles at the time of the treatment. I understand that I will have to wear protective eyeglasses during the course of the treatment to protect my eyes from the laser light.

I am aware that the laser treatment can produce, but is not limited to the following common side effects: redness, swelling, welting, itching, tingling, and dry skin. I understand that these side effects usually last from 2 hours to a couple of days.

I understand there are risks and complications that can occur from a laser treatment that can interrupt my daily life, work routine or social life. These may include but are not limited to: burning scab formation, heat rash, bruising, scarring, infection, hypopigmentation (lighter skin), and hyperpigmentation (darker skin). If any of these were to occur, I understand our physician is available to see me and provide post treatment guidelines to speed my recovery time. If I choose to consult my own physician or seek any other medical attention it is at my own expense.

For best results, I have been informed that multiple treatments will be needed. For most areas 6-10 treatments are necessary to achieve desired hair clearance. I understand that more that 10 treatments may be needed depending on hair type, previous methods of hair removal and skin color. I understand results are not guaranteed. Some of the factors that could trigger new hair growth are hormonal imbalance, pregnancy, medications, menopause, tweezing, or waxing.

I understand that tanning during the course of my laser treatments is not recommended and can cause a number of complications. I understand that I should avoid direct sun exposure for 2 weeks after my laser treatment, this also includes tanning beds. I have been informed to use a sunblock with an SPF of 30 or higher on the treated area during the course of the laser treatments. I understand it is my responsibility to inform MEDICAL Staff if my skin is any darker than when treatment first started.

I understand post-treatment care is very important after the treatments and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of any complications.

I consent to having photographs taken during the course of my laser treatments to be retained as part of my file maintained by MEDICAL Staff. I understand all photographs are the property of MEDICAL Staff, and are kept confidential. I have read and understood all information presented to me before signing this consent. I have had ample opportunity to ask question regarding laser hair reduction, side effects and after care. I also understand it is my responsibility to inform MEDICAL Staff of any medical or prescription changes.

Signed: _____
(Patient of person legally authorized to consent for patient)

Date: _____

Reviewed By: _____
(Medical Director)

Date: _____

Disclosure and Consent – Laser/Light Assisted Treatment of Vascular/Pigmented Lesions

- I (we) voluntarily request laser/light assisted treatment of lesions that I have proclaimed as "unwanted" in the following areas: _____.
- I (we) voluntarily consent and authorize that this laser/light assisted treatment be performed by the staff of this clinic, including physicians, technicians, associates, technical assistants, and other health care providers as deemed necessary by the staff of this clinic. I (we) hereby release this clinic, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.

- For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I (we), the undersigned, consent to have this clinic's staff take before, during, and after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involved area(s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at this clinic.

- I (we) recognize that this laser/light assisted treatment is not an exact science and I (we) acknowledge that no guarantees or assurances have been made to me (us) as to the result or cure. There are risks related to the performance of these procedures. I (we) understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:

  1) Infection – Albeit rare, skin infection is a possibility any time a skin procedure is performed. I acknowledge and understand that although rare, it is possible for a skin infection to become a blood-borne wide spread infection.
  2) Blood clots in veins and lungs –Albeit extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.
  3) Allergic reactions – Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.
  4) Hemorrhage and bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I (we) have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.
  5) Recurrence of the lesion – I may not experience permanent results even with multiple treatments.
  6) Painful or unattractive scarring – Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow ***all postoperative instructions*** carefully.
  7) Discomfort and pain – Some discomfort will be experienced during and after the laser treatment. I give my permission for the administration of topical and/or local injection of anesthesia when and if deemed appropriate.
  8) Pigment changes (skin color) – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
  9) Poor healing – The resultant open wound may require more than the usual one to three weeks to heal.
  10) Sun exposure – Once the surface has healed, it may be pink and sensitive to the sun. Treated areas should be blocked completely, that a sun block with and SPF greater than 40 should be used at all times in areas not protected by clothing, whether or not I am in the sun.
  11) Blindness and eye damage – The laser, without protective eyewear, may cause visual loss including blindness. ***It is important to keep these shields on at all times*** during the procedure and that I ***should keep my eyes closed*** in order to protect my eyes from accidental laser exposure.
- I (we) understand and acknowledge that I have been informed by means of visual aids, as well as individual discussion, that multiple treatments are often required to cause long-term results and that some patients have no results even with multiple treatments. The usual number of treatments required is two to three, but more treatments may be required.
- I (we) have been given an opportunity to ask questions about my condition, alternate forms of anesthesia and treatment, the procedure to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give the informed consent. By signing below, I (we) certify that I (we) have read and fully understand the contents of this document and that I (we) have received and understand all of the disclosures referred to herein. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

_____	_____
Signature of Patient	Signature of Person Authorized to Consent for Patient
_____	_____ _____
Print Name of Patient	Print Name Relationship
_____	_____
Date	Witness

PRE - PHOTOFACIAL INSTRUCTIONS

- Skin must not be tan. Tanning the skin prior to or after Photofacial in NOT advised!

- If you have a history of cold sores, you will want to take prevention prior to, the day of, and the day following your Photofacial treatment.

- If you are taking medications which cause photo-sensitivity, you will need to obtain the prescribing physician's permission to discontinue the day before your treatment.

- If you are using a topical Retin A, Tazorac, Differin, Renova or any other topical retinol product, you will need to discontinue the day before your treatment.

- If you are pregnant, or should become pregnant during your treatment series, we would need to discontinue your treatments until a later date.

- If you have taken Accutane within the last 6 months, we will need to schedule your treatment series for a later date.

- Puffiness and swelling are common reactions to Photofacial and typically go away quickly.

- People with pacemakers or an internal defibrillator are not good candidates for Photofacial.

- Photofacial is typically a series of up to 5 treatments administered 4 weeks apart.

POST - PHOTOFACIAL INSTRUCTIONS

 Although not typical, you could experience some prolonged redness, crusting or flaking. You may use ice or a cool, wet cloth if needed after treatment to cool the skin. Ibuprofen or Tylenol may be used for discomfort.

 You may apply Aloe Vera gel or Aquaphor Healing Ointment to treated area.

 Wash treated areas with a gentle cleanser. NO exfoliants for 48 hours! Wash with cool water – avoid hot water for 48 hours post treatment. DO NOT scrub your skin!!

 Moisturizer and make-up may be applied after washing, if desired.

 Stringent used of recommended sunscreen on treated areas is strongly advised for all patients, 365 days per year.

 Stay out of the sun! If planning to be in the sun, wear a broad-brimmed hat in addition to your sunscreen. ALWAYS use a sunscreen with an SPF of 30 or higher and reapply every 1-2 hours of exposure time. This includes running outside, gardening, hiking, fishing, bicycling, etc.

 Avoid aerobic activities 24 hours following each treatment.

 Puffiness and swelling are common reactions to photofacial treatments and should subside quickly. If either should continue beyond 24-hours, we can prescribe an oral anti-inflammatory to speed up the healing process.

 Begin the recommended skin care program the morning following treatment or return to your regular skin care regimen.

Post Laser/Light Treatment Care – Vascular / Pigmented Lesions

1. Be careful with hot water and do not bathe with very hot water until healed.
2. Keep the area moist with Aloe Vera gel, or Aquaphor Healing Ointment until inflammation resolves and the area is healed.
3. Keep the treated area out of the sun. If sun is unavoidable, cover it or block it with SPF 40 or above for at least 4 weeks following treatment.
4. Keep clothing from rubbing the treated area and avoid other irritation to the area.
5. Do not use hairspray on or around the treated area.
6. Notify the clinic should you have any prolonged redness, excessive puffiness, or other unusual side effects.

Important Facts to Remember

1. There will be redness, and occasionally, mild blistering of the treated areas lasting for several hours to 3 - 14 days.
2. The treated area might “crust”, “flake”, or look like a “cat scratch”. This should resolve within 3 - 14 days.
3. Each area to be treated usually requires two or more treatments approximately 2-12 weeks apart.
4. It might be impossible to remove the lesion forever. Even though the lesion may be diminished or “disappear” for long periods of 3-6 months, it might return in the future. The fact that the lesion responded to treatment and was disabled for an extended period almost invariably means it will respond to future treatment.
5. Medications Dispensed: _____ use as directed.

_____ _____
Signature of Patient Signature of Person Authorized to Consent for Patient

_____ _____ _____
Print Name of Patient Print Name Relationship

_____
Date

SKIN REJUVENATION CONSULTATION

Personal Information			
Name		Home Phone	
Address		Work Phone	
City		State	
Postal Code		Date of Birth	
Referred by		Gender	Male/ Female

Medical History			
Bleeding disorder, bruise easily		Endocrine / hormone issues	
Pigmentation disorder		Pacemaker / defibrillator	
History of cold sores		Accutane within 6 months	
History of keloid scarring		History of skin cancer	
Dermatological conditions		Photoallergic	
List any medications taken			
Medical conditions			
List any allergies			

Contraindications:

- Tanned skin (active or passive)
- Accutane taken in last 6 months
- History of keloid scarring
- Any abnormal or undiagnosed pigmentation should be avoided
- Atypical moles or malignancy
- Non-intact skin (i.e. sores, psoriasis, eczema, infection, rash) should be avoided
- Recent chemical or mechanical peeling in treatment area (within 2 weeks)
- Laser resurfacing in treatment area within 3 months
- Any medical condition involving impairment of skin structure, esp healing patterns
- Poorly controlled diabetes
- Pregnancy

Precautions: (treat with caution if patient has any of following risk factors)

- Medications that may cause photosensitivity to light 540-950 nm
- Healing impaired
- History of skin cancer in treatment area, family history of melanoma

Skin Type Assessment			
Fitzpatrick Skin type	**I II III IV** V VI	Ethnicity	
Tan present	Yes / No	Sunscreen daily?	Always/ Sometimes/Never
Skin care regimen			
Vascular lesions			
Pigmented lesions			
Textural irregularities			

**Improvements achieved by each treatment may not be evident until weeks later.*

Hair Assessment			
Location (circle)	Upper lip Chin Sideburns Forehead Cheeks Other_____		
Hair density	Sparse/ Medium/ Dense	Hair thickness	Fine/ Medium/ Coarse
Hair color		Other	

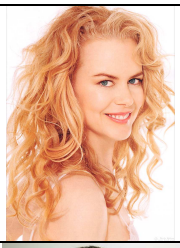
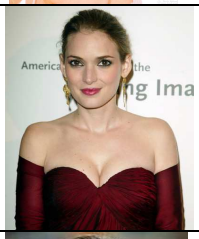
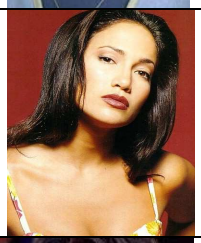
**counsel patient that hairs in treatment area may also be reduced or miniaturized as result of skin rejuvenation treatment. Base line photos/photodocumentation is recommended.*

Possible Side Effects:

- Temporary mild discomfort from treatment, may feel warmth or tingling
- Temporary swelling, redness in treatment area
- Temporary 'darkening' of pigmented lesions before becoming lighter
- Superficial scabbing, crusting or blister
- Transient or permanent dyschromia from epidermal injury

Treatment Schedule:

- Treatment done at monthly intervals. May retreat as soon as 3 weeks for some patients.
- 5 treatments in treatment series. Some lesions may fade significantly after a single treatment. Collagen stimulation is a delayed and cumulative response, 5 treatments recommended for this indication.
- Maintenance treatments may be done to help maintain results, or to treat new lesions.

Fitzpatrick Skin Types	Example	Tanning
I		**Never tans** **Always burns**
II		**Occasionally tans** **Usually burns**
III		**Tans on average** **Sometimes burns**
IV		**Usually tans** **Rarely burns**
V		**Mostly tans** **Almost never burns**
VI		**Never burns**