OptiLight by Lumenis

GOLDEN EYES OPTOMETRY

Treatment Consent Form Please read and initial each statement. Complete, underline or circle individual selection accordingly.	Initials
I authorize Dr. _____ to perform IPL™ treatments on me in an effort to improve Meibomian Gland Dysfunction / Blepharitis / Chalazion / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia	_____
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	_____
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 the 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 anti-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	_____

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I agree to review the following IPL pretreatment 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 400 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, 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

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	Any known allergy?	NO	YES
	Any tattoo and/or pigmented lesion on the 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?
P L S R V L	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?
S R V L	Intake of aspirin or anti-coagulants?	NO	YES
	Easy bruising?	NO	YES
My signature below certifies that I have duly read and understood the content of this informed consent form, and have provided accurate information as to my current health condition. I hereby freely consent to Optilight/Stellar M22™IPL skin treatments			_____

- ⬜ Add Package Information Here
- ⬜ Add Package Information Here
- ⬜ Add Package Information Here

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Name of patient (please print)	Signature of patient	Date
Name of witness (please print)	Signature of witness	Date