

Surname				First Name				
Address								
City			State			Postcode		
Mobile			Work Ph					
DOB			Family Doctor					
Gender	M F <i>(Please circle)</i>		Family Doctor Phone					
Emergency Contact				Emergency Contact Phone				

Which body area/areas or condition would you like treated? _____

Please answer **ALL** of the following questions:

Medical History Information		Please Circle	
1. Do you have ANY current or chronic medical illnesses? Disclose any history of heat urticaria, diabetes. autoimmune disorders or any immunosuppression, blood disorders. cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders or any other condition or illness.		YES	NO
Please List			
2. Do you have ANY current or chronic skin conditions? Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.		YES	NO
Please List			
3. Are you currently under a doctor's care?		YES	NO
List Reason			
4. Do you take/use ANY medications (prescriptions and non-prescription), vitamins, herbal or natural supplements, on a regular or daily basis?		YES	NO
Please List			
5. Are there ANY topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?		YES	NO
Please List			
6. Do you take/use ANY systemic/oral steroids (e.g. prednisone, dexamethasone)?		YES	NO
7. Do you have ANY allergies to medications? foods, latex or other substances?		YES	NO
Please List			
8. Are you receiving, or have you received gold therapy? (rheumatoid arthritis)		YES	NO

Medical History Information		Please Circle	
9. (For women) are you or could you be pregnant?		YES	NO
10. (For women) are your menstrual periods regular?		YES	NO
11. (For women) have you ever been diagnosed with Polycystic Ovarian Disorder?		YES	NO
12. Do you have a history of Herpes I or II in the area to be treated?		YES	NO
13. Do you have a history of Keloid scarring or Hypertrophic scar formation?		YES	NO
14. Do you have a history of light Induced Seizures?		YES	NO
15. Do you have ANY open sores or lesions?		YES	NO
16. Do you have ANY history of radiation therapy in the area to be treated?		YES	NO
17. In the last six (6) months. have you used ANY of the following? Anticoagulants or blood-thinning medications: photosensitizing medications: anti-inflammatory medications		YES	NO
List Product name and date last used			
18. In the last three (3) months, have you used ANY of the following products: glycolic acid or salicylic acid; alphahydroxy or betahydroxy acid products		YES	NO
List Product name and date last used			
19. In the last three (3) months, have you used ANY exfoliating or resurfacing products or treatments?		YES	NO
List Product name and date last used			
20. Do you or have you ever had ANY permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane etc. ?		YES	NO
List locations on/in the body and dates			
21. Do you or have you ever had ANY Botulinum's such as Botox or Dysport etc. ?		YES	NO
List locations on/in the body and dates			
22. Have you taken Accutane (or products containing isotretinoin) in the last 12 months?		YES	NO
23. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months?		YES	NO
24. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?		YES	NO

Patient signature		Dated	
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DISCLAIMER: This sample documentation/consent form is for general information purposes only and not intended as legal advice. Cryomed does not accept liability for its contents. It is essential that each clinic customise the consent form according to treatment procedure, state law requirements, specific local requirements, language and insurance compliance. Cryomed does not make any representation, guarantee or warranty, express or implied or assume any liability or responsibility for the accuracy or completeness of the contents of this sample form. You should seek your own legal advice independently or through your insurance policy provider along with insurance advice.

Informed Consent—Tattoo

The PicoSure laser produces an intense burst of light that is absorbed by the pigmented lesion or tattoo ink.

All personnel in the treatment room, including me, will wear protective eyewear to prevent eyedamage from this intense light.

The sensation of the laser light on skin is uncomfortable and may feel like a slight prickle or the sensation of heat. These sensations may last for a few hours.

Prior to the treatment, test spots may be performed. Test spots help to determine effectivetreatment settings.

Tattoos may blister and have pinpoint bleeding for a few days after treatment.

Following a pigment treatment, the treated areas may be red, slightly swollen; pigment may darken and slough off in 7-10 days.

The area should be treated delicately following treatment. Do not pick on scabbing/blistering. Multiple treatments may be necessary.

I have been informed that hyperpigmentation (darkening of the skin), and hypopigmentation(lightening of the skin) are possible complications of the procedure and the incidence of this occurring are higher for darker skin types ☐ Yes ☐ No

I understand that sun exposure, as well as not adhering to the posttreatment instructions provided to me may increase my chance of complications.

I agree to have before and after pictures taken of the area to be treated: Yes ☐ No ☐

I have read and understood all information presented to me, and I have been given an opportunity to ask questions before signing this consent.

Consent for treatment of:			
Patient Name		Physician/Operator Name	
Patient Signature		Physician/Operator Signature	
Dated		Dated	

Informed Consent—Focus Treatment

The PicoSure laser using the Focus lens array produces an intense burst of light. All personnel in the treatment room, including myself, will wear protective eyewear to prevent eye damage from this intense light.

Prior to the treatment, test spots may be performed. Test spots help to determine effective treatment settings.

The sensation of the laser light on the skin may feel like a slight prickle or the sensation of heat. The sensation of heat may last for an hour or longer after the treatment. Cold air or a cool gel pack may be used during treatment or post treatment to cool the skin and to minimize warmth. You will also hear a slight snapping sound during the treatment and feel the touch of the laser distance gauge (part of the device) in the treated area.

Following the procedure, you may have redness or slight swelling in the treated area; this may last for 24 hours. You may also develop an acne-like breakout or slight darkening of the pigment; this should resolve without intervention in 3-7 days.

The area should be treated delicately following treatment. Multiple treatments may be necessary.

Posttreatment:

- Cool the skin posttreatment as needed with cold gel packs, aloe vera gel, or cool air.
- Wash the treatment area gently with soap and water; do not soak the treated areas.
- Apply moisturizer for sensitive skin.
- Do not shave the treated area if crusting is evident
- Avoid sun exposure between treatments. If sun exposure is unavoidable, use a 30+ sunblock to protect exposed, treated areas.
- For patients who are prone to break outs or have sebaceous skin, consider waiting 24 hours before applying any topical products

I have been informed that hyperpigmentation (darkening of the skin), and hypopigmentation (lightening of the skin) are possible complications of the procedure and incidence of this occurring are higher for darker skin types: Yes ☐ No ☐

I understand that sun exposure, as well as not adhering to the posttreatment instructions provided to me may increase my chance of complications.

I agree to have before and after pictures taken of the area to be treated: Yes ☐ No ☐

I have read and understood all information presented to me, and I have been given an opportunity to ask questions before signing this consent.

Consent for treatment of:			
Patient Name		Physician/Operator Name	
Patient Signature		Physician/Operator Signature	
Dated		Dated	

Pretreatment/Posttreatment Instructions

Precautions to take before your light-based treatment:

- No sun exposure, tanning beds and sunless tanning cream for 4 weeks prior to treatment. Sun exposure decreases the effectiveness of the laser treatment and can increase the chance of Post treatment complications.
- Use a broad spectrum UVA/UVB sunscreen with an SPF of 30 or higher. Apply to the treated area every 2 hours when exposed to the sun and it is recommended to make this a part of your skin care routine.
- Remove all makeup, creams or oils prior to treatment.
- Be sure to inform your care provider if you have ever had cosmetic tattoos or cosmetic pigmentation or permanent makeup applied near the area of treatment

Instructions following your laser treatment:

General (Pigment and Tattoo):

- Cleanse the treated area at least daily with water and mild soap, and then pat the area dry.
- Do not rub or scratch the treated area.
- If crusting/scabbing occurs, do not shave or pick area. Apply Aquaphor ointment (tattoo) or other moisturizer (face) to the area 2-3 times a day. Keep the area moist, and let the crusting/scabbing resolve on its own.
- If you are prone to break outs or have oily skin, consider waiting 24 hours before applying any topical products
- Discomfort may be relieved by cold gel packs and/or an over the counter pain reliever, such as acetaminophen.
- Avoid contact sports or any other activity that could cause injury of the treated area.
- Avoid swimming, soaking or using hot tubs/Jacuzzis until the skin heals.
- Contact physician if there is any indication of infection (redness, tenderness or pus).

Tattoo:

- After cleansing and while skin is still moist, apply a thin layer of Aquaphor® ointment to the treated tattoo.
- Apply a non-stick pad over the tattoo until it is healed
- Avoid sun exposure to the treated area. Use a broad spectrum UVA/UVB sunscreen with an SPF of 30 or higher. Apply to the treated area every 2 hours when exposed to the sun and it is recommended to make this a part of your skin care routine.
- Clean area daily with mild soap and water and pat dry.
- Do not shave the treated area if crusting is evident.
- Avoid sun exposure between treatments. If sun exposure is unavoidable, apply SPF 30+ to protect exposed, treated areas.
- Apply moisturizers for sensitive skin as needed
- For patients who are prone to break outs or have sebaceous skin, consider waiting 24 hours before applying any topical products
- Do not rub or scratch the area.
- Discomfort may be relieved by using cool gel packs or acetaminophen.
- If blistering occurs, keep the area moist by applying Aquaphor 3 times per day or antibiotic ointment per recommendation of the physician. Do not enter swimming pools or hot tubs until treated areas are healed.
- No swimming or using hot tubs for 48 hours posttreatment.

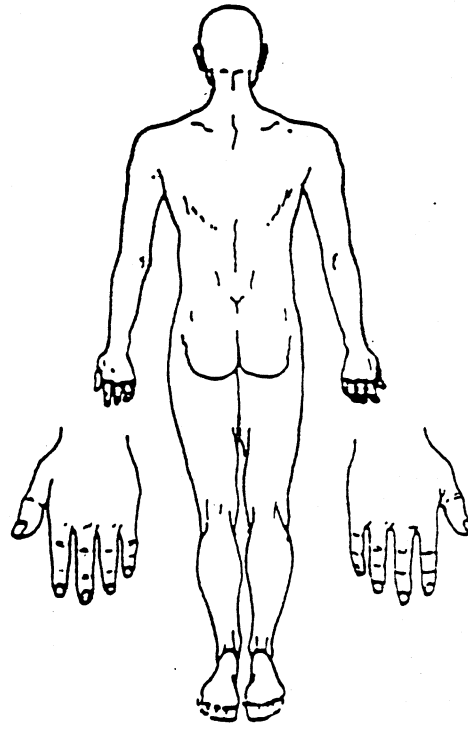
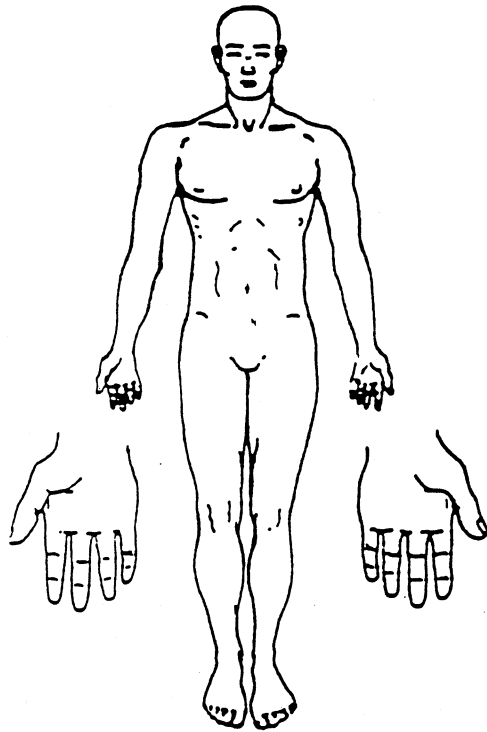
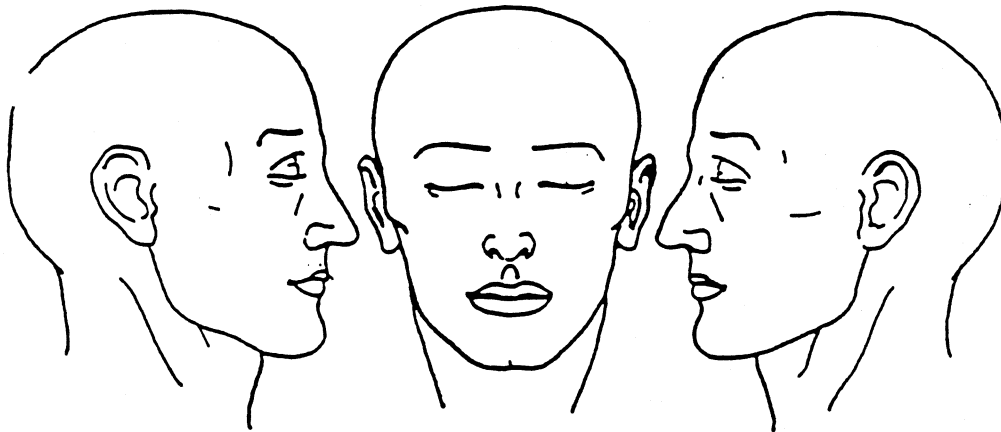
Patient Name		Age	
Diagnosis		Location	
Comments			

Laser Wavelength: ☐ 755 nm ☐ 532 nm ☐ 1064 nm

☐ Test Spot ☐ Treatment

Treatment	Date	SpotSize (mm)	Fluence (J/cm²)	Rep Rate (Hz)	No of Pulses	Area Treated	Anesthetic	Boost Used
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Treatment Record—Description and Location



Patient		Date	
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Comments	
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Consultation Record – Tattoo

Skin Type: I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐

Location of the tattoo: _____

Area to be treated: _____

Age of tattoo: _____

Ink colors: _____

Description of the tattoo: _____

Size of tattoo: _____

Patient has history of red ink or other allergies? Yes ☐ No ☐

If yes, please list allergies: _____

Presence of scarring in tattoo area: Yes ☐ No ☐

Discussed with patient:

- Process and procedure ☐
- Discomfort ☐
- Optional use of topical numbing cream ☐
- Aftercare instructions ☐
- Realistic expectations ☐

Possible complications discussed with the patient:

- Risk of hyperpigmentation or hypopigmentation ☐
- Risk of scarring ☐

Physician/Operator Signature		Date	
Comments			