**Demonstration**

**&**

**Training Consent**

**Form Only**

Hologic (Australia) Pty Ltd

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Surname |  | | | First Name |  | |
| Address |  | | | | | |
|  | | | | | | |
| City |  | | State |  | Postcode |  |
| Mobile |  | | Work Ph |  | | |
| DOB |  | | Family Doctor | |  | |
| Gender | **M F** *(Please circle)* | | 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 |  |

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 eye damage 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 effective treatment 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

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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 giving 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 |  |

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# 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

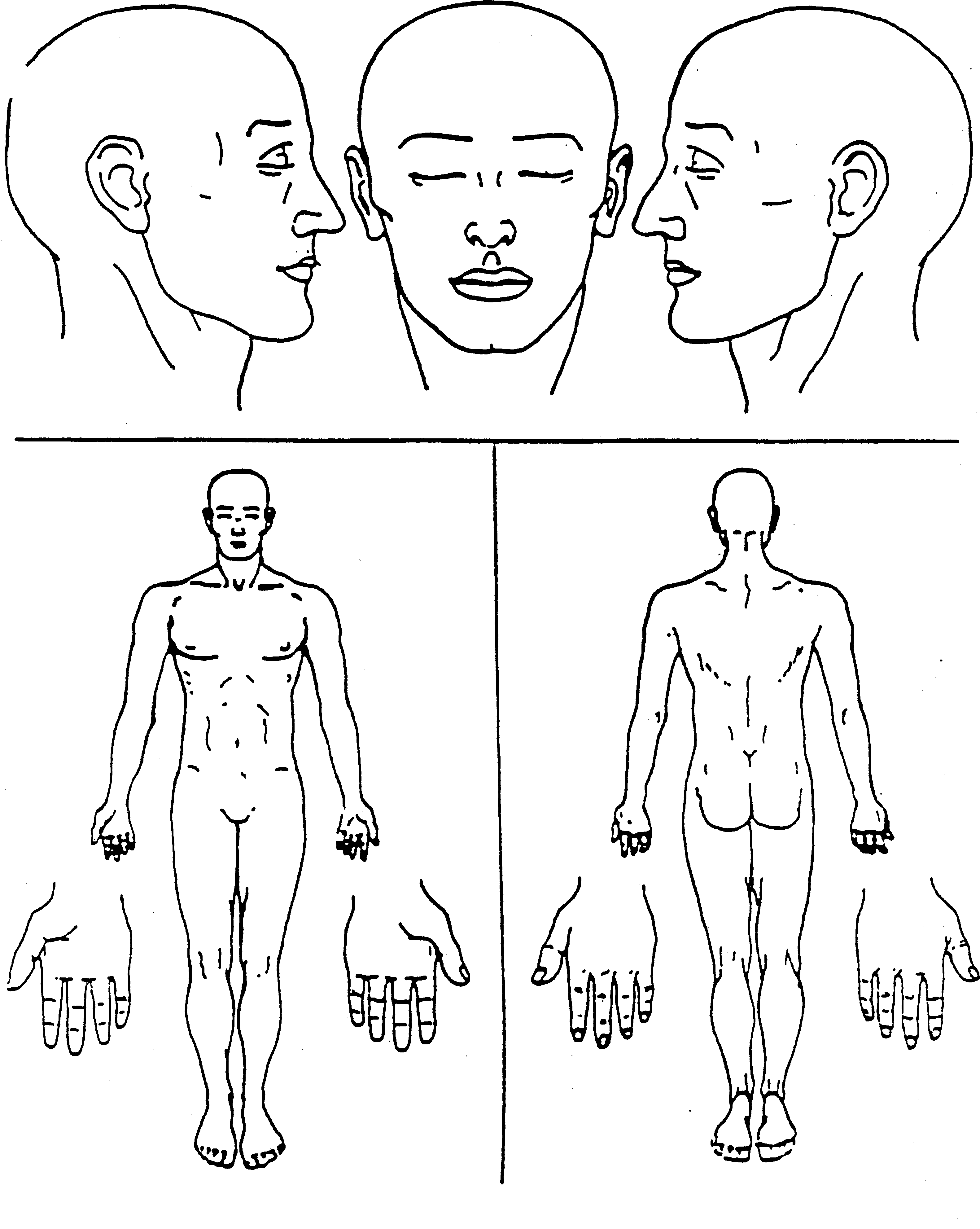
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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Treatment** | **Date** | **Spot Size (mm)** | **Fluence (J/cm²)** | **Rep Rate (Hz)** | **No of Pulses** | **Area Treated** | **Anesthetic** | **Boost Used** |
| **1** |  |  |  |  |  |  |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

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# Treatment Record—Description and Location



|  |  |  |  |
| --- | --- | --- | --- |
| Patient |  | Date |  |

Comments

**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 |  | | |