Doctor/Practice Name

Address

Phone

****

PATIENT CONSENT FORM DATE:

NAME: D.O.B.

Pre-Treatment Photos Taken:  YesNo

Do not sign this form without reading and understanding its contents.

GUIDE TO V·LASER Nd:YAG LASER TREATMENT

V·Laser is one of the most advanced lasers available today for the treatment of vascular lesions, dyschromia and pigmentation, and skin rejuvenation.

V·Laser offers more capability and more treatment efficacy than any other pulsed-dye laser, Nd:YAG/KTP laser or IPL system for the treatment of vascular and pigmented skin lesions. V·Laser uses 8-micropulse technology that allows the physician to increased treatment efficacy or reduce patient downtime as required.

When compared to IPL devices used for the treatment of pigmented lesions, V·Laser treats with less discomfort, achieving better results in fewer treatments. Achieve excellent results in the treatment of a number of non-vascular lesions, including warts, psoriasis, poikiloderma of Civatte, striae, hypertrophic scars, and acne scars. It is also an excellent pre-treatment option to improve the results of fractional CO2 treatments.

NUMBER OF TREATMENTS REQUIRED

We can only ESTIMATE the number of treatments it will take to completely remove the tattoo. Your practitioner will provide you with a more accurate estimate of the requirement.

V·LASER Nd:YAG TREATMENT PROCESS

Before starting each treatment session, photos will be taken to chart your progress. With this information we can evaluate your progress and discuss the need for continued treatment. The decision to continue is always made jointly and with a clear understanding of potential outcomes.

The use of protective eyewear is essential during laser treatment. It is also advisable to keep your eyes closed. All personnel in the treatment room will wear protective eyewear.

Prior to the commencement of the treatment proper, the practitioner will perform test spots to determine the most effective treatment settings.

The sensation of laser light impacting on the skin in the treatment area will feel like a pin-prick and you will have the sensation of heat. This will last for a few hours after treatment.

WHAT ARE THE POSSIBLE SIDE EFFECTS OF V·LASER TREATMENT?

With each treatment, some redness, bruising, swelling, blistering and crusting is common, but wound infection is rare. Irregular pigmentation and mild texture changes can occur as a result of laser treatment, but these changes usually return back to “normal” over a few months. Rarely, these changes can be permanent. True scarring with the newest, most advanced lasers is rare.

We advise patients to protect the wound as you would any other minor burn for a few days. A dressing may help to protect the area and minimize further injury. Cold compresses and over the counter analgesics like paracetamol, can be taken for minor discomfort during the first few days. Most patients are able to resume normal activity and work the same day. Showering and bathing are usually not a problem, but sun exposure should be avoided in the treated area. It is very important to follower our instructions carefully especially regarding the use of any medications or specific wound care that we may recommend.

Procedural consent FOR V·LASER Nd:YAG LASER

patient’s declaration

Treatment with the V·Laser Nd:YAG Laser is planned for the following condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the risks of the procedure include possible pain, bleeding, infection, scarring, drug reactions and unforeseen complications. There is also the risk of patchy residual pigment, persistence of tattoo pattern, change or permanent lightening of skin colour, change in skin texture, or hair loss or thinning. Previous treatment by any method may increase any or all of these risks.

I understand my responsibility for properly fulfilling the appropriate aftercare instructions as explained by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, his/her staff, and/or written or videotaped instructions provided.

I further agree that any photos or videotape taken of me may be used for other teaching or publication, if considered appropriate, unless I notify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in writing that he/she is not to use these photographs in such a manner.

The procedure is generally considered cosmetic, and is not covered by insurance. I understand that I am responsible of all costs of treatment(s).

I have been asked at this time whether I have any questions about this procedure and I do not have any further questions. I understand the procedure, accept the risks, and request that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and/or his/her assistant perform this procedure on me.

I have disclosed my medical history to my practitioner, and answered all questions regarding my health to the best of my ability and knowledge.

Photographs:  
I authorise the taking of clinical photography and its use for scientific purposes both in publication and presentations. I understand my identity will be protected.

The nature of V·Laser Nd:YAG Laser tattoo removal treatment has been explained to me. I understand that just as there may be benefits from the procedure, all procedures involve risk to some degree. I am aware that other unexpected risks or complications may occur and that no guarantees or promises have been made to me concerning the results of the procedure. It has also been explained that during the course of the proposed procedure, unforeseen conditions may be revealed requiring performance of additional procedures. My questions regarding this treatment, its alternatives, its complications and risks have been answered by my practitioner and/or his or her staff.

My signature on this consent form indicates that I have read and that I understand the information provided. I consent to the treatment described, and I agree to comply with the requirements placed on me by this consent form.

PATIENT’S NAME:

PATIENT’S SIGNATURE: DATE

nurse / therapist’s declaration

I have fully explained to the patient the nature and purpose of V·Laser treatment and the potential risks associated with the treatment. I have asked the patient if he/she has any questions regarding this treatment or the risks associated with it, and have answered all questions to the best of my ability.

THERAPIST’S NAME:

THERAPIST’S SIGNATURE: DATE:

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