Light Sheer Consent Form

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

Initials

I authorize _____ to perform LightSheer QUATTRO treatments on me in an effort to achieve hair reduction.
Wrinkles / Other: _____ _____

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 instructions will help reduce this possibility. I understand the below list of short-term effects.

I understand the below list of short-term effects and agree to follow matching guidelines:

- A burn is possible
- Hyper- or hypo-pigmentation is possible
- Treated area could take 3-6 months to heal
- With recommended aftercare guidelines are crucial for healing prevention of scarring and hyperpigmentation
- Discomfort - During the procedure and shortly after, I might experience an itching sensation which degree will vary per condition treated, area sensitivity and treatment head use. This sensation does not last long and a mild “sun-burn” sensation may follow for typically up to one hour and might be reduced with application of cooling and soothing creams. _____
- Perifollicular or perilesional erythma/ordema - severity and duration of the rash 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 inflammatory creams.
- Puffiness/redness post wrinkle treatment - Typically dissipates within a couple of hours
- Micro-crusting over some areas with very dense and coarse hair/pigmented lesions - may take 5 to 10 days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring
- Bruising may rarely occur and may last several days

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 throughly 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 the results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many session will be required _____

I consent to photographs being taken for the purpose of documenting my progress and response to treatment. Photographs will be kept solely in my file. _____

I consent to photographs being taken for medical education or publication with applied discretion and not revealing my identity _____

I agree to review the following laser pre-treatment compliance checklist along with my physician and bring accurate and updated data, to the best of my knowledge _____

Name: _____

Address: _____ Phone Number: _____

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FITZPATRICK SKIN TYPE: I ☐ II ☐	III ☐	IV ☐ V ☐ VI ☐
Natural and 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 Wart, Ginko Biloba, etc...) or aromatherapy (essentials oils)	NO	YES
Diseases which may be stimulated by light at 805nm or 1060nm, 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, active acne, 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 or keloids	NO	YES
History of livedo reticularis	NO	YES
History of erythema ab igne	NO	YES
Intake of isotretinoin within the past 6 months	NO	YES
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES
Any known allergies	NO	YES
Any tattoos, permanent make-up and/or dysplastic nevi on requested treatment area that should be protected	NO	YES
Intake of aspirin or anti-coagulants	NO	YES
Easy bruising	NO	YES
Swollen legs or pain after long standing/sitting	NO	YES
Previous vein surgery on requested treatment area (sclerotherapy, stripping, etc...)	NO	YES
Horomonal 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
Previous skin procedures on requested treatment area (botox, fillers, peels, metal implants, threads, etc...) Within the past 6 weeks	NO NO	YES YES
List of additional current medication taken		

My signature certifies that I have duly read and understood the content of this informed consent form and gave the accurate information as to my health condition. I hereby freely consent to LightSheer®QUATTRO™ treatments

_____

Name: _____

Address: _____ Phone Number: _____