IPL Consent Form

Only indicate if your answer is YES. Leave blank for NO.

DO YOU HAVE A **HISTORY** OF:

- lupus or porphyria
- migraines, seizures, or epilepsy
- Koebnerizing isomorphic diseases *(vitiligo, psoriasis)*
- skin cancer
- cold sores or rashes in the planned treatment area
- keloids

HAVE YOU HAD ANY OF THE FOLLOWING WITHIN **1 YEAR PRIOR** TO FIRST TREATMENT:

- isotretinoin intake
- radiation therapy to the head or neck
- hair removal procedures on treatment area *(IPL, laser, wax, etc.)*
- aesthetic skin procedures on treatment area *(Botox, fillers, peels, etc.)*

WITHIN **6 MOS PRIOR:**

- ocular infections
- ocular or eyelid surgery
- neuro-paralysis

WITHIN **3 MOS PRIOR:**

- photosensitive herbs or medication such as: *Isotretinoin, Tetracycline, Doxycycline, or St. John's Wort?*
- treatment with chemotherapeutic agent

WITHIN **3-4 WEEKS PRIOR:**

- exposure to natural or artificial sun
- use of self-tanner

DO YOU **CURRENTLY HAVE** ANY OF THESE CONDITIONS:

- uncontrolled infections
- uncontrolled immunosuppressive diseases
- active cancer
- receiving chemo or radiation
- HIV
- active lupus or porphyria
- hormone disorder *(PSOC, etc.)*
- diabetes
- uncontrolled allergies
- uncontrolled eye disorders
- possibly or currently pregnant
- postpartum
- nursing

ARE YOU **CURRENTLY TAKING**:

- photosensitive herbal preparations *(St John's Wort, Ginkgo Biloba, etc.)* or aromatherapy *(essential oils)*
- aspirin or anti-coagulants

DO YOU **CURRENTLY HAVE**:

- active cold sores
- inflammatory skin conditions *(dermatitis, etc.)*
- pre-cancerous lessions, skin cancer, or pigmented lesions on treatment area
- lesions to be treated that have changed in color, size, texture, or border
- suntan, sunburn, or applied artificial tanning products
- hair on area not to be removed
- tattoo(s) on area to be protected
- pigmented lesion(s) in treatment area that should be protected

WITHIN **8 WEEKS AFTER**, ARE YOU PLANNING ON HAVING:

- radiation therapy
- chemotherapy

1. **I authorize the Doctors at Center Eye Care to perform IPL treatments on me** in an effort to improve dry eye disease due to meibomian gland dysfunction which may be caused be one or more of the following: dyschromia / hyperpigmentation / hair reduction / PWS / hemangioma / angioma / rosacea / telangiectasia.
2. **I understand that without eye protection,** IPL applied near the eyes may cause severe ocular complications.
3. **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.
4. **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 & it is important not to manipulate or pick which may lead to scarring.
   - **Discomfort:** During the procedure, I may experience a sensation similar to a rubber band snap, the degree of which will vary per my skin condition and area sensitivity, but that it does not last long. A mild 'sunburn' sensation may follow for typically up to one hour and can be reduced by applying cooling and soothing creams.
   - **Reddening and swelling:** Severity and duration depend on the intensity of the treatment, and the sensitivity of the treatment area. These phenomenacan be reduced by applying cooling and/or anti-inflammatory creams.
   - **Bruising:** This rarely occurs and may last up to 2 weeks.
5. **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 of complications.
6. **The procedure, as well as potential benefits and risks,** have been thoroughly explained to me, and all related questions have been answered.
7. **Pre and post-care instructions** have been discussed and are completely clear.
8. **I understand that results may vary** with each individual. I acknowledge that it is impossible to predict how I will respond to treatment, and that the number of sessions required can vary.
9. **I consent to photographs being taken** for the purposes of documenting my progress, treatment response, and results. Photos will be stored solely in my medical record.
10. **I consent to photographs being used for medical education** or education publication with applied discretion and will not reveal my identity.
11. **I agree to review the IPL pre-treatment guidelines.**

My signature certifies that I have read and understand the content of this informed consent form, and that I gave accurate, historical, and current medical data - to the best of my knowledge. I hereby consent to OptiLight IPL treatments conducted by Center Eye Care.

Patient Name

Patient Signature *Date*