ACNE Treatment Consent

CONSENT FORM - ACNE TREATMENT

DOB *: _____ dd / mm / yyyy

authorize North Eastern Health Specialist to perform hair removal with the BBL / Nd-Yag laser on the following area(s) of my body

The Dermatologists at the North Eastern Health Specialists are trained in the use of BBL and class 4 medical lasers. A certificate in the Safety of Laser Use has been obtained by all members trained in the use of this equipment at NEHS. These members include Dr Shireen K Sidhu (Dermatologist), Dr Hoang Ly (Dermatologist), Mrs Sharon Habib (Registered Nurse), Mrs Helen Marzola (Registered Nurse)

BBL (BroadBand Light) for the use in Acne Treatment utilizes light to destroy or minimize P. acnes bacteria, reduce inflammation, and minimize over production of sebaceous oil glands. This therapy may utilize multiple BBL filters (420 nm, 560 nm, 590 nm) to target selectively the P. acnes bacteria and sebaceous oil glands. The goal is to pack the skin with light to impact the entire pilosebaceous unit.

Treatment schedule

Patient's with known allergies to anesthetics will list them here

Consent *

- [ ] I understand that all standard safety precautions and all BBL specific guidelines will be followed to ensure the utmost in safety during my treatments. This includes the use of protective eyewear at all times while the equipment is in use.

Consent *

- [ ] I am aware of alternative methods of treatment for hair removal such as topical products, oral treatments and other light-based or laser systems as discussed with my Dermatologist. I have explored such alternatives to my satisfaction, and have made an independent decision to proceed with BBL treatments.

Consent *

- [ ] My Fitzpatrick skin typing has been analyzed, and I understand that a higher Fitzpatrick typing increases the potential risk of the treatment. Hormonal therapy and other medical conditions may also affect my results. Hair removal with BBL is limited to skin types I-V as complications of the procedure increase with greater skin types. The Nd-Yag laser will be used for skin type VI to prevent the risks described.

Consent *

- [ ] Results are cumulative; therefore a series of treatments is necessary to achieve maximum benefit. Actual results cannot be guaranteed.

Consent *

- [ ] I will avoid sun tanning, tanning booths and tanning creams for at least 3 weeks prior to and after all BBL treatments to reduce the risks of uneven pigmentation.

Consent *

- [ ] I understand that Roaccutane (or other Retinoids taken orally) should not be used for 6 months prior to this procedure.

Consent *

- [ ] Retin-A (or similar products containing isotretinoin) should not be used 24 hours prior to treatment to minimize irritation. These topical retinoids may be used again one week after the procedure.

Consent *

☐ I understand that treatments cannot be done on skin areas with open sores or lesions. I understand that tattoos and permanent makeup may be altered and that moles may be lightened. We therefore do not treat disease within tattoos and all moles are covered up so as to not be accidentally treated.

Consent *

☐ I understand that recurrent viral infections such as herpes simplex (cold sores) or varicella (shingles) may be activated and that NEHS needs to be informed if there is a history of this. An oral antiviral treatment may be prescribed over the 3 days before, during and after laser/BBL treatment in order to reduce the risk of this infection.

Consent *

☐ I will advice my dermatologist if I am on any anticoagulant (blood thinning) medication (including aspirin) or if there is a history of excessive bleeding or bruising.

Consent *

☐ I will also inform my dermatologist if I have had a history of sun sensitivity or if I am using any sun sensitizing medications. I agree to provide NEHS with an accurate personal medical and drug history prior to treatment.

Consent *

☐ As laser lights may bounce of reflective objects, I understand that all reflective objects such as jewellery and watches must be removed if near the treatment area.

Consent *

☐ I acknowledge receipt of pre and post treatment instructions and that I fully understand that failure to follow these may affect my treatment outcome and increase the likelihood or severity of complications. I also agree to carefully follow these post treatment instructions to reduce the likelihood or severity of any skin changes.

Consent *

☐ I agree that this consent shall apply to all subsequent treatments of a similar nature.

Consent *

☐ I understand that although every reasonable effort will be made to achieve a desirable outcome no guarantees are stated or implied.

Consent *

☐ I certify that I am a competent adult of at least 18 years of age (Minors under 18 years of age require additional consent from a parent or legal guardian.)

Photography - I consent to photographs and other audio-visual and graphic materials before, during, and after the course of my therapy to be used for medical, marketing, and education purposes. *

○ do ○ do not

Patient's Name (Printed) *: _____

Patient Signature *

Date *: _____ dd / mm / yyyy **Name of Doctor/ Reg. Nurse *:** _____

Signature of Doctor/ Reg. Nurse *

Date *: _____ dd / mm / yyyy