Enlighten laser consent form

Patient name

Date of birth

Treatment area(s)

Date of treatment

DISCLAIMER

Enlighten laser is an advanced laser treatment that uses both picosecond and nanosecond pulse durations to target unwanted pigmentation, tattoos, and certain skin irregularities. It works by delivering rapid bursts of energy that break down pigment particles into tiny fragments, allowing the body's immune system to naturally clear them away. This technology is also used for skin rejuvenation, improving tone and texture, and reducing acne scars.

Risks inherent in the procedure include redness, swelling, blistering, temporary or permanent pigment changes (hyperpigmentation or hypopigmentation), scarring, infection, and, rarely, allergic reactions to tattoo ink fragments released during treatment. Risks inherent in refusing the procedure may include persistence of unwanted pigmentation or tattoos, continued dissatisfaction with skin appearance, and no improvement in texture or scarring. Risks specific to me may depend on my skin type, pigment depth, tattoo ink type, medical history, medications, and history of abnormal scarring or pigmentation changes.

Expected benefits of the treatment include significant fading or complete removal of pigmentation or tattoos, improved skin clarity, and enhanced texture. Potential disadvantages of the treatment include the need for multiple sessions, temporary skin sensitivity, and incomplete clearance in some cases. Alternative procedures and their pros and cons include Q-switched laser treatment (effective for certain pigments but may require more sessions), dermabrasion (more invasive with higher risk of scarring), chemical peels (limited effect on deeper pigments), and choosing to leave the pigmentation/tattoo untreated. Uncertainties include the number of sessions required for optimal results, the degree of clearance achievable, and individual healing responses. Follow-up treatment may include additional laser sessions, topical aftercare, sun protection, and scar or pigment management if needed.

INFORMED CONSENT AND PHOTOGRAPHY

I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about:

- the aims/motivations for having the procedure and the desired outcome
- the risks inherent in the procedure
- the risks inherent in refusing the procedure
- the risks specific to me
- the expected benefits of the treatment
- the potential disadvantages of the treatment
- alternative procedures and their pros and cons – including the option of no treatment at all
- any uncertainties about and the likelihood of success of the procedure
- any follow-up treatment that may be required

Clinical photographs and videos: I agree to and authorize the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records.

I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

CONSENT CONFIRMATION

Do you understand the information you have been provided?
◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?
◯ Yes ◯ No

Has your consent been freely given?
◯ Yes ◯ No

MEDICAL SCREENING

Do you have any medical conditions?
◯ Yes ◯ No

Are you pregnant or breastfeeding?
◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?
◯ Yes ◯ No

Do you have an autoimmune disease?
◯ Yes ◯ No

Do you have any skin conditions?
◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?
◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?
◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?
◯ Yes ◯ No

YOUR HISTORY AND GOALS

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

☐ I will retain this information throughout the course of my treatment and refer to it as required

SIGNATURES

Patient signature _____ Date _____

Practitioner name and signature _____ Date _____