Woodbridge Dermatology
& Laser Centre

www.woodbridgedermatology.ca

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DERM-ECLAT Depigmentation Treatment
CONSENT FORM

The Derm-Eclat Depigmentation Treatment is intended to help eliminate pigmented blemishes on the face. The main action of the Derm-Eclat Treatment is based on the inhibition of tyrosinase, a basic enzyme in the melanin formation process. Several of the active ingredients in the Derm-Eclat formulation act by blocking this enzyme, or even by reversing the pigmentation process.

My practitioner has informed me that the Derm-Eclat Depigmentation Treatment begins with an in-office treatment. During the office treatment, the Der-Eclat mask is applied by the Medical Aesthetician.

I understand that the mask must remain on my face for 10 (ten) hours, as indicated by the Medical Aesthetician. The activation time will range 5 to 8 hours.

I understand that the Derm-Eclat Depigmentation Treatment involves a strict home regimen that must be followed accordingly. I understand that this program cannot be interrupted under any circumstances during the time prescribed.

I understand that it is forbidden to associate the Derm-Eclat treatment with any other depigmentation treatment. This would include peel treatments of any kind, any other lightening products of any kind, and any laser/IPL/semi-ablative/ablative treatments of any kind during my full treatment program. Failure to comply may result in the appearance of undesirable results and, therefore, the physician and his/her practice/clinic cannot be held liable whatsoever.

My practitioner has informed me that during the first two days of treatment, and in the case of especially sensitive skin, the skin my run reddish in colour. In addition, a sensation of heat and tightness of the face can be observed. Also, the skin will start to peel after 48 hours; I will not pick or peel the skin when it exfoliates, but let the skin repair naturally and use the assigned home care. This is perfectly normal and must not lead to any modification of the home care guidelines.

I agree to return for follow up in 6 (six) weeks.

I agree to photographs being taken to evaluate treatment effectiveness.

I have the opportunity to ask any questions, and they have been answered to my satisfaction.

I understand the procedure and accept the risks and request the procedure be performed on me.

Patient Name: _____

Patient Signature: _____ Date: _____