Woodbridge Dermatology
& Laser Centre

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DISCLOSURE AND CONSENT FOR VASCULIGHT/LASER TREATMENT

- ☐ **IPL (Intense Pulsed Light)** Photorejuvenation
- ☐ **Nd: YAG**
- ☐ **VL/PL**
- ☐ **EPI (hair removal)**

➢ I voluntarily request treatment of the following that I have proclaimed as "unwanted" in the following areas:

➢ I voluntarily consent and authorize that this treatment be performed by the staff of this clinic, including physicians, technicians and aestheticians as deemed necessary by the staff of this clinic. I hereby release this clinic, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.

➢ For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I the undersigned consent to have this clinic's staff take before, during, and after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involving area(s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at this clinic.

➢ I recognize that this laser-assisted treatment is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result or cure. There are risks related to the performance of these procedures. I understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:

1. **Discomfort and pain**: Some discomfort will be experienced during and after the laser treatment. I give my permission for the administration of topical and/or local injection of anesthesia when and if deemed necessary.

2. **Infection**: Albeit rare, skin infection is a possibility any time a skin procedure is performed.

3. **Hemorrhage and bruising:** Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.

4. **Recurrence of the lesion:** I may not experience permanent results even with multiple treatments

5. **Painful or unattractive scarring:** Scarring is a rare complication of laser-assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow ***all postoperative instructions*** carefully.

6. **Pigment changes (skin colour):** During the healing process, the treated area may become either lighter or darker in colour than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

7. **Poor healing:** The resultant open wound may require more than the usual one to three weeks to heal.

8. **Sun exposure:** Once the surface is healed, it may be pink and sensitive to the sun. Treated areas should be blocked completely, that a sun block with an SPF greater than 40 should be used at all times in areas not protected by clothing, whether or not I am in the sun. Some medications can make a patient sensitive to light.

9. **Blindness and eye damage:** The laser, without protective eyewear, may cause visual loss including blindness. It is ***important to keep these shields on at all times*** during the procedure and that I ***should keep my eyes closed*** in order to protect my eyes from accidental laser exposure.

- I understand and acknowledge that I have been informed by means of visual aids, as well as individual discussion, that multiple treatments are often required to cause long-term results and that some patients have no results even with multiple treatments.

- I have been given an opportunity to ask questions about my condition, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give the informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all of the disclosures referred to herein.

- I agree to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publication or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

- I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

Patient's Name:_____

Patient's Signature:_____ **Date:**_____