

SelectSkin MD
Consent for the ResurFX, ND:YAG, Q-SWITCHED LASER with
Lumenis M22

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

-I authorize Katy Jankauskas, CME or Alyssa Ostby P.A or Charlene Moore P.A to perform fractional non-ablative laser resurfacing on my skin in an effort to improve_____. Initials_____

-Pre and Post-care instructions have been discussed and are completely clear to me. Initials_____

I understand that optimal results are achieved with a series of treatments and that I will not see optimal results after one treatment, nor can the doctor guarantee my satisfaction with the level of improvement or % improvement even after multiple treatments. The need to complete a treatment plan has been fully explained to me. Also, I understand that clinical results may vary depending on my response to laser and my compliance with pre- and post-treatment instructions. I have followed all pre-laser requirements previously provided to me and, I understand and will follow the recommendations provided here for post treatment care of my skin, which have been discussed with me.

Initials_____

-I understand that there is a rare possibility of side effects or serious complications post treatment, including pigmentary changes and scarring. I am aware that careful adherence to all advised instructions will reduce the possibility of complications.

Initials _____

-I understand the below list of short-term effects and skin responses and agree to follow the guidelines:

-DISCOMFORT-during the procedure, I might experience a hot needle pricking sensation which degree will vary per my skin condition and area sensitivity. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams.

Initials_____

-REDDENING AND SWELLING:-severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with the application of post-cooling and or inflammatory cream.

Initials_____

-XEROSIS AND PRURITIS- within the first few days after treatment, my skin may feel itchy, tight and dry, Regular application of moisturizers helps reducing this sensation.

Initials_____

-BRONZED APPEARANCE- Within the first few days after treatment, I may develop a pinkish and/or colored tone and discrete dry flaking. It is important that I do not rub nor pick my skin which may ether wise lead to scarring. A broad spectrum (UVA/UVB) sunscreen SPF 30 or greater should be applied to the area(s) to be treated whenever exposed to the sun.

Initials_____

-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 for complications.

Initials_____

-The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my questions answered to my satisfaction.

Initials_____

-I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to treatment and how many sessions will be required for the expected level of improvement.

Initials_____

-I consent to photographs being taken for the purpose of documenting my progress and response to treatment and be kept solely in my medical record.

Initials_____

-I consent to photographs being used for education and possible public use with applied discretion not revealing my identity. (this is optional) Yes or No _____

-I agree to review the laser pre-treatment compliance checklist below along with my physician and bring accurate and updated data, to the best of my knowledge. _____

Skin Type I ___ II ___ III ___ IV ___ V ___ VI ___
Recent exposure to sun in the 4-6 weeks pre-op plan, remaining suntan or artificially toned skin No _____ YES _____
Photosensitivity or use of photosensitive (to 1565nm) medication and/or herbal preparations NO _____ YES _____ (what/when) _____
Intake of isotretinoin within the past 6 months NO _____ YES _____
Concurrent inflammatory skin conditions (dermatitis, active acne, rosacea, etc...) NO _____ YES _____ (what/when) _____
Presence or history of active cold sores or herpes simplex virus NO _____ YES _____
Immune-compromised conditions NO _____ YES _____ (what) _____
History of post-inflammatory hyperpigmentation NO _____ YES _____
Medical history of keloids NO _____ YES _____
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis) NO _____ YES _____ (what) _____
Multiple dysplastic nevi in area to be treated NO _____ YES _____
Active cancer (currently on chemotherapy or radiation) NO _____ YES _____
Previous skin Cancer NO _____ YES _____
Any tattoo and/or pigmented lesion on requested treatment area that should be protected NO _____ YES _____
Pregnant or possibility of pregnancy, postpartum or nursing NO _____ YES _____

Previous skin procedure on requested treatment area (Botox, Fillers, peels, etc.....) NO _____ YES _____ (what/when) _____ _____
Any known allergy? NO _____ YES _____ (what) _____
List of additional current medication taken:

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to M22 ResurFX laser treatment.

_____ Initials

 Name of patient (please print) Date

 Signature of patient Date

 Name of witness and signature Date