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SURGERY

CONSENT FOR FRACTIONATED (DOT) LASER THERAPY

Patient's Name:_____ **Date**_____

PLEASE CHECK EACH BOX AFTER READING. If you have any questions please ask your doctor.

- ❑ I have been informed that I have the following conditions(s) premature aging of skin, sun damage skin, acne scars, scars, uneven pigmentation and excess rhytids.

- ❑ The procedure(s) to treat my condition(s) has/have been described to me as DOT laser of: face, eyelids, neck, chest, arms and hands.

- ❑ I have been told of the following treatment options, and the risks and benefits of each have been explained:

  - ☐ No Treatment
  - ☐ Chemical Peel
  - ☐ Dermabrasion
  - ☐ Surgical Excision
  - ☐ Laser Resurfacing
  - ☐ Blepharoplasty
  - ☐ Brow Lift, Face Lift, Platysmaplasty
  - ☐ Other_____

- ❑ Fractionated laser therapy is a process by which laser light is applied to the skin in an attempt to change the appearance of lines, wrinkles, skin blemishes, scars and certain other localized skin conditions. Laser skin resurfacing will neither stop the aging process nor totally eliminate wrinkles. The final result of treatment may not be apparent for several months. Future treatment may be necessary, depending upon the success of this initial treatment. Some results will be attained from the very first treatment, but 3-5 treatments are recommended.

- ❑ Treated areas will have a reddish appearance that will persist for several weeks or longer. At the junction between treated and untreated areas, a different skin color or blotching may occur. The texture of the skin may be permanently altered. Deep areas of skin wrinkling may be minimized or softened, but not eliminated. Areas of deep skin scarring (usually from acne) may require additional resurfacing treatment. The risk of infection is rare, but should it occur, topical and/or systemic antibiotic therapy may be necessary.

- ❑ Fractionated laser therapy usually causes some discomfort and swelling. Oozing typically occurs and the area may become covered with a crust which will dissipate in a few days. A skin dressing may be applied to aid in healing. If no dressing is used, it will be necessary to clean the lasered area 2 times daily and to keep the area covered with prescribed medications or ointments. Failure to do so may have negative effects on healing and the final result of surgery.

- ❑ Hyper-pigmentation (the color of the treated areas becomes darker than the surrounding skin) is the most common side effect. Certain medications may be prescribed or recommended to help minimize this effect. Hypo-pigmentation (lightening of the skin color) is a rare complication. Both of these pigment complications usually fade in 6-12 months; however, they may be permanent.

- ❑ Small whitish bumps, called milia, may occur. They may require local treatment or medication to help them clear.

- ❑ Scarring, although rare, is a possible complication. The scars may be hypertrophic scars that are thickened scars, and/or keloid scars that are abnormal, raised scars that may extend beyond the limits of the original scar.

- ❑ Ectropion, an outward turning of the eyelids, may occur with laser treatment of the lower lids. It is usually temporary, but may require further treatment, including additional surgery. Laser energy can cause eye injury, including blindness. Corneal protection will be used during your procedure and may cause an abrasion.

ADDITIONAL INFORMATION

- ❑ This is elective, cosmetic surgery and I understand that results may vary due to individual patient differences. It is possible that my skin condition may worsen and that selective re-treatment may be required. I realize there can be no guarantee that the proposed treatment will be curative (healing) or meet all aesthetic (sense of beauty) expectations.

- ❑ I have provided a full and truthful health and social history, including drug, alcohol and tobacco use. I understand that withholding information may delay healing and jeopardize the planned goals of surgery.

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- ❑ I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that lack of cooperation can increase risks and complications.
- ❑ If any unforeseen condition should arise during surgery that may call for additional or different treatment from that planned, I authorize my doctor to use professional judgment to provide appropriate care.
- ❑ I consent to the taking of photographs, video or audio recordings and agree to be interviewed for medical, scientific, or educational purposes. Filming or photographing an operation may include my face and may reveal my identity.
- ❑ I have reviewed / viewed pre-operative and post-operative instructions.

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

_____ *(Initial)* I agree to avoid direct sunlight for two (2) weeks after treatment and to use sun block of at least SPF 30 for 3 months thereafter.

_____ *(Initial)* I hereby state that I have stopped all tobacco use 6 weeks prior to the procedure, recognizing their negative effect on healing and will not restart the use of tobacco for at least 6 months.

_____ *(Initial)* I will not drink more than 2 glasses of wine or other alcohol beverage per 24 hour period during the healing period.

_____ *(Initial)* I have started the antiviral and antibiotic medicines prescribed to me.

_____ *(Initial)* I have been using the Obagi regiment or Hydroquinone as directed for at least 2 weeks.

_____ *(Initial)* **Please inform your doctor if you have used Accutane®, Isotretinoin or any other medications prescribed by your physician or dermatologist during the past year. It is also very important to advise your doctor if you have ever had cold sores or other blister lesions on your face.** I have not used accutane in 2 years.

INFORMATION FOR FEMALE PATIENTS

_____ *(Initial)* I understand that I am not a candidate for DOT laser surgery if I am pregnant, might be pregnant, or am nursing a child because of the use of topical anesthesia.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in, and any inapplicable paragraphs were stricken before I signed. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date