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## KTP and NdYAG Laser Vein and Lesion Removal CONSENT FORM

***Please read and initial each statement.***

I have read and understood the **KTP and NdYAG Laser Vein and Lesion Removal Information and Treatment Instructions** and have had an opportunity to ask questions that have been satisfactorily answered. \_\_\_\_\_

I authorize the physician, nurse or laser technician to perform vein treatment with the NdYAG on me. \_\_\_\_\_

The cost of treatment has been discussed with me and I agree to pay this amount. \_\_\_\_\_

***I understand:***

- the goal of spider vein and skin lesion treatment is to improve or remove their appearance. Spider veins and development of certain skin lesions are a chronic condition and the goal is to control and not cure them. Every individual is unique which makes it difficult to guarantee a specific number of treatments needed. Results vary with the individual depending on underlying vein issues that may not be present at this time. I may require **multiple treatments** to see improvement. \_\_\_\_\_
- expected side effects of laser vein and lesion treatment includes **redness, swelling, crusting, burning** sensations. These should improve over **1 to 3 days but may last longer**. Possible infrequent complications include **blistering, infection, bruising or discolouration**. These complications are usually temporary. Rarely, scarring and permanent discolouration can occur. There may be risks not yet known at this time. \_\_\_\_\_
- **eye damage** may occur if protective eyewear provided is not worn. \_\_\_\_\_
- the risk of side effects increases with treatment of facial veins because this is a more sensitive area. I am aware there are other options for treating facial and non-facial spider veins. \_\_\_\_\_
- every person is unique and although good results are expected, it is impossible to guarantee. \_\_\_\_\_

- many of these side effects are worsened by intentional or accidental sun exposure. The use of a good quality SPF product daily is highly recommended. \_\_\_\_\_
- there may be an increased occurrence of side effects if I do not follow the post procedure instructions. \_\_\_\_\_
- laser treatments are not recommended if you are pregnant or breastfeeding, if you have active infection at the site, if you are taking photosensitizing agents such as Accutane or Gold therapy and/or certain herbal medications such as St John's Wort or Ginkgo Biloba, have an unwillingness to wear SPF products, have tattoos in the area to be treated, have a history of light sensitive seizures, keloid formation, melasma. None of these conditions apply to me. \_\_\_\_\_
- there are other options for treatment. I have had an opportunity to discuss these including not having the procedure. \_\_\_\_\_
- the risk of side effects increases with other medical situations such as immunodeficiencies (diabetes, HIV, smoking, being on immune suppressants such as prednisone) that can be associated with poor skin healing and increased risk of infection. None of these conditions apply to me. \_\_\_\_\_
- I should call the clinic if I have any questions or concerns about my treatment. I will notify the clinic if I experience any complications as soon as possible. \_\_\_\_\_

I authorize the taking of clinical photographs for:

- my clinic record \_\_\_\_\_
- research and education (discretion applied) \_\_\_\_\_
- publication \_\_\_\_\_
- the U Cosmetic website (discretion applied) \_\_\_\_\_
- the U Cosmetic Brag Book kept in the clinic (discretion applied) \_\_\_\_\_

I have read and understand this **KTP and NdYAG Laser Vein and Lesion Removal Consent Form**. My questions have been answered satisfactorily by the doctor or nurse. I accept the risks and complications of the procedure.

Patient name (please print)	Date	Signature
Witness name (please print)	Date	Signature

*love being U*