San Diego ENT

RESURFX CONSENT

PLEASE READ AND INITIAL EACH STATEMENT. COMPLETE, UNDERLINE OR CIRCLE INDIVIDUAL SELECTION ACCORDINGLY.

Initials

- I authorize Doctor to perform fractional non-ablative laser resurfacing on my skin in an effort to improve. _____
- Pre and post-care instructions have been discussed and are completely clear to me. _____
- 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 help reduce this possibility. _____
- I understand the below list of short-term effects and skin responses and agree to follow matching guidelines:
    - **Discomfort** – during the procedure, I might experience a hot needle pricking sensation, the degree of which will vary per my skin condition and area sensitivity. A mild "sunburn" sensation may typically follow for up to one hour and will be reduced with application of cooling and soothing creams.
    - **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 application of cooling and/or anti-inflammatory creams. _____
    - **Xerosis and pruritus** – within the first few days after treatment, my skin may feel itchy, tight and dry. Regular application of moisturizers helps reduce this sensation.
    - **"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 I do not rub nor pick my skin, which may otherwise 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.
- 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. _____
- The procedure, as well as potential benefits and risks have been thoroughly explained to me, and I have had all my related questions answered. _____
- I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required for the expected level of improvement. _____
- I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record. _____
- I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity. _____
- 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 procedures on requested treatment area (Botox, fillers, peels, etc...)	NO ☐ YES ☐ What/When?
Any known allergy?	NO ☐ YES ☐ What/When?
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 ResurFX™ laser treatment.

Name of patient (please print) _____ Signature of patient _____ Date _____

Name of witness (please print) _____ Signature of witness _____ Date _____