San Diego ENT

STELLAR IPL CONSENT

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

Initials

- I authorize Doctor Reuther to perform IPL treatments on me in an effort to improve Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia / Other: _____ _____
- I understand that there is a rare possibility of side effects or serious complications, including permanent discoloration 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 agree to follow matching guidelines:
    - **Flaking of pigmented lesions** – crusts may take five to 10 days to disappear, and it is important not to manipulate or pick which may otherwise lead to scarring.
    - **Discomfort** – during the procedure, I might experience a sensation similar to a rubber band snap that will vary in degree per my skin condition and area sensitivity, but that does not last long. 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.
    - Bruising may rarely occur and may last up to two weeks.
- 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. _____
- Pre and post-care instructions have been discussed and are completely clear to me. _____
- 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. _____
- 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 following IPL pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge. _____

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HR PL SR VL	Skin type of the area to be treated: I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐	
	Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan	NO ☐ YES ☐
	Use of self–tanners or tan enhancer caps within the past 3-4 weeks pre-op plan	NO ☐ YES ☐
	Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc.) or aromatherapy (essential oils)	NO ☐ YES ☐ _____
	Diseases which may be stimulated by light at 400 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria	NO ☐ YES ☐ _____
	Pregnant or possibility of pregnancy, postpartum or nursing	NO ☐ YES ☐
	Inflammatory skin conditions (dermatitis, etc.)	NO ☐ YES ☐ _____
	Presence or history of active cold sores or herpes simplex virus	NO ☐ YES ☐
	HIV	NO ☐ YES ☐
	Active cancer (currently on chemotherapy or radiation)	NO ☐ YES ☐
	Previous skin cancer?	NO ☐ YES ☐
	Medical history of keloids	NO ☐ YES ☐
	Intake of isotretinoin within the past year	NO ☐ YES ☐
	Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO ☐ YES ☐ _____
	Any known allergy?	NO ☐ YES ☐ _____
	Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	NO ☐ YES ☐
	List of additional current medication taken	
HR	Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO ☐ YES ☐ _____
	Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc.)	NO ☐ YES ☐ _____
PL	Any observed modification (color, size, texture and border) on the lesion to be treated?	NO ☐ YES ☐ _____
SR	Any hair on requested treatment area that should not be removed?	NO ☐ YES ☐
VL	Age of lesion onset?	
PL SR	Previous skin procedures on requested treatment area (Botox, fillers, peels, etc.)	NO ☐ YES ☐ _____
SR	Intake of aspirin or anti-coagulants?	NO ☐ YES ☐ _____
VL	Easy bruising?	NO ☐ YES ☐

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 **Stellar M22™ IPL skin** treatments. _____

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

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