# Clinic 5 Laser

**Date:**

460 6th Street
Courtenay, BC V9N1M3

## DIOLAZE - INFORMED CONSENT FORM

**Name:** _____ **DOB** _____

**Medical History:** *Please inform physician or laser technician prior to treatment if you have any of the following conditions that may make you unsuitable for DIOLAZE treatments.* ***Please circle YES or NO:***

- □ Pregnancy or nursing. **YES or NO**
- □ Under 18 years of age. **YES or NO**
- □ Pacemaker or internal defibrillator. **YES or NO**
- □ Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance. **YES or NO**
- □ Current or history of cancer, especially skin cancer, or pre-malignant moles. **YES or NO**
- □ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV or use of immunosuppressive medications. **YES or NO**
- □ Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases. **YES or NO**
- □ A history of diseases stimulated by heats, such as recurrent Herpes Simplex in the treatment area (prophylactic treatment may be given) **YES or NO**
- □ Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/ freshly tanned skin. **YES or NO**
- □ History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry, cracked, ulcerated, infected and fragile skin. **YES or NO**
- □ Tattoos, permanent make-up, pigmented lesions (to be kept). **YES or NO**
- □ Any medical condition that might impair skin healing. **YES or NO**
- □ Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction. **YES or NO**
- □ Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing. **YES or NO**
- □ Use of Isotretinoin (Accutane) within 6 months prior to treatment. **YES or NO**

*This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with DIOLAZE technology. If you have any questions before your treatment, please feel free to ask.*

- I hereby authorize Kristie McKay and/or such assistants as may be selected to perform the DIOLAZE procedure.
- My medical history is on file.
- I have received the following information about the technology:
  - DIOLAZE is a non-invasive technology that utilizes Diode laser 810nm, for hair removal with highest speed, the best skin cooling system for hairs of dark blond-black color and skin type I-IV.
  - No complete clearance is guaranteed.
  - Treatment requires a number of sessions.
  - Exact number of sessions is individual.
  - There may be some discomfort and transient redness and/or swelling associated with treatment.
  - There is a small risk of adverse reactions.

# DIOLAZE Informed Consent Form

**Name: First** _____ **Last** _____

- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper-or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure, unforeseen conditions may necessitate different procedures than this above and I authorize the provider to perform such other procedures, if they find them professionally desired.
- I understand that not everyone is a candidate for this treatment and results may vary therefore, there is no guarantee as to the results that may be obtained.

**The procedures to be used to treat my conditions have been explained to me.**

**Patient Initials:** _____ **Technician Initials:** _____

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. Any questions I may have asked, have all been answered to my satisfaction.
3. I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity, not exposing my face.

_____ _____

Patient Signature Technician: Signature

_____

_____

Patient Name: (PRINT) DATE

Or person authorized to sign for patient