Laser Consent

_____ I understand that the purpose of this procedure (CO2 laser skin resurfacing/Erbium ResurFx Laser Skin Resurfacing/Intense Pulse Light/Hair removal with/without dermal fillers) is for ____________________________.
There are several alternatives to treatment including but not limited to other laser treatments, chemical peels, facial rejuvenation or no treatment at all.

_____ I understand that the possible risks of the procedure include crusting, pain, swelling, redness, bruising, scarring, blistering, hypopigmentation, hyperpigmentation, motting of skin vascularity or purpura and unforeseen complications. Eye injury is possible but unlikely. Eye protection measures will be properly used throughout laser treatment sessions.

_____ I understand that a single procedure will most likely fail to completely remove all my dyschromia, or textural problems in the area treated. Individual response will vary according to skin types, hair color, degree of tanning, follow-up care, and the body area being treated.

_____ I understand that treatment may be painful, but this is typically manageable without any pain relief medication. I agree to receive local analgesic, sedative and amnestic medications before, during, and after the procedure for patient comfort and pain control. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, it at all. Unprotected sun exposure in the weeks following treatment is contraindicated as it may worsen this condition. Blistering of the skin may occur. Scarring can occur but is uncommon. I understand that there is no guarantee that the procedure will resolve my concerns.

_____ I further agree that any pictures or video taken of me may be used for teaching, publication, or advertising, if considered appropriate, unless I notify the doctor in writing that he or she is not to use these photographs prior to publication.

_____ I have been asked at this time whether I have any questions about this procedure and do not. I understand the procedure and risks, accept the risks, and request that this procedure be performed on me by the doctor and/or qualified staff.

________________________________________________________________
Signature of Patient                   Date

________________________________________________________________
Signature of Witness                   Date

________________________________________________________________
Signature of Practitioner               Date
Check List for Laser Treatment

The following is a check list for you to complete.

_____ My surgeon is Jose Barrera, MD, FACS.

_____ My laser treatment is scheduled for (date)______________________________________

_____ My laser treatment is scheduled for (date)______________________________________

_____ I have received medical clearance from my primary care physician or specialist, if indicated by my surgeon.

_____ My pre-treatment appointment in is scheduled for ________________________________

_____ My post-treatment appointment in is scheduled for_______________________________

_____ I have received a prescription for pre- and post- Laser treatment medications.

_____ I know what medications I should and should not take prior to treatment. I understand that if advised to take any medications I will take them with only a sip of water.

_____ I have received a copy of the Pre and Post Laser treatment information sheet.

_____ I will wear loose, comfortable clothing to the procedure visit on the day of treatment.

_____ I have informed my physician of known allergies to medications which include:

______________________________________________________________________________.

Name of Patient (please print) __________________________ Date __________________________

______________________________________________________________________________

Signature of Patient
Pre and Post Laser Treatment Information Sheet

Procedure Medications

Eye drops
- **Tobramycin Ophthalmic Solution** – use 2 drops at night time or four times a day as directed the day after the procedure.

Prophylactic anti-viral
- **Valtrex (Valacyclovir) 500 mg.** Take one capsule twice a day x 7 days. Start one day before the procedure.

Antibiotics
- **Keflex (Cephalexin) 500 mg.** Take one twice a day x 10 days to start one day before the procedure.
- **Doxycycline 100 mg.** Take one tablet twice a day x 10 days to start one day before the procedure.

Miscellaneous
- **Hydrocodone with Acetaminophen 5mg/325 mg.** Take one tablet every 4 – 6 hours as needed for severe pain.
- **Celebrex 100 mg.** Take one tablet every 4 – 6 hours as needed for moderate pain.
- **Tylenol 500 mg.** Take one tablet every 4 – 6 hours as needed for mild pain.
- **Valium (diazepam) 5 mg.** Take one tablet the night before the procedure as needed for anxiety. Take one tablet the day of the procedure as directed.

Laser Post Procedure List

- Gentle Cleanser (wash 4x/day): SkinCeuticals Gentle Cleanser or Cetaphil (OTC)
- Occlusive Ointment (apply 4x/day for 3 days): SkinCeuticals Hydra Balm, Aquaphor ointment (OTC), or Vasoline ointment (OTC)
- Non-Occlusive Moisturizer (apply 3x/day starting on day 4): SkinCeuticals Epidermal Repair, Cerave Lotion (OTC), or Cetaphil (OTC)
- Sun block 50+ SPF (apply 2-3 hrs x/day, starting on day 5): SkinCeuticals Fusion, Sheer, or Matte UV Defense
- Lubricating eye drops (any OTC)
- Cool Compressions: Frozen peas or face cool pack for first 3 days
- Mineral Make-up after day 7
- Steroid cream/ointment (prescription given by the doctor if needed)
- Hat to protect treated area from sun exposure

______________________________________________ __________________
Name of Patient (please print) Date

______________________________________________
Signature of Patient