Laser Hair Removal

Pre- Treatment Instruction

- Avoid tanning for 3 weeks before treatment.
- Use a sunscreen
- Do not wax or have electrolysis for 6 weeks before treatment.
  You may shave or use depilatory cream until 3-14 days before treatment, however, stubble should be slightly visible on the day of treatment.
- Retin-A topicals must be discontinued in treatment area 2 weeks prior to treatment. (Dr. prescribed)
- Use of antibiotics or steroids must end two weeks prior to any treatment due to photosensitivity.

Note: Stubble representing dead hair being shed from the hair follicle will appear within 10-20 days from the treatment date.

POST-TREATMENT ADVICE TO PATIENT

- Shortly after treatment areas will be tender, slightly red and swollen. This reaction usually disappears within a few hours.
- Blisters may occur in sensitive areas such as bikini line and neck areas.
- Oozing, crusting and scabbing may occur within 1-3 days.
- Do not pick or remove scabs.
- Apply antibiotic ointment (Polysporin, Bactroban, Fucidin or Hydrocortisone) twice daily until healed.
- The area will heal in 5-7 days. If you experience itching, antihistamines such as Benadryl may be taken 1-3 days if required.
- For the first 2-3 days apply an ice pack for 15 minutes a few times a day if you have swelling.
- Make up should be avoided for 3-4 days until the site has healed.
- If you go into the sun or cold, cover the site with non-stick dressing such as Telfa pads.
- After the area has healed avoid sun for 2 months and use sunscreen of SPF 30 or higher.
- You may shower the next day after laser treatments. The treated area may be washed gently with a mild soap.
- The skin should be patted dry and NOT rubbed.

Contraindications for laser Hair Reduction

- Pregnancy
- History of Keloid scarring
- White/light blond/gray hair
- Dr prescribed topical retinoids used in
- the area (3 months)
- Accutane
- Light allergy
- Recent chemical peel 30% of hydroxy
- acids and above (3 weeks)
- Medium depth peels (Jessner, TCA)-3
- months
- Diabetes Type I (insulin injections)
- Sun Tan
- Sun sensitizing medication

LASER HAIR REMOVAL CONSENT

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

INITIALS:

_____ · I authorize tech ______________________ to perform LightSheer®QUATTRO™ treatments on me in an effort to improve Hair Reduction on areas:

____

_____ · I understand that there is a rare possibility of side effects or serious complication 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:

- **Discomfort – during the procedure and shortly after, I might experience an itching sensation which degree will vary per condition treated, area sensitivity and treatment head used. This sensation does not last long and a mild "sun-burn" sensation may follow for typically up to one hour and might be reduced with application of cooling and soothing creams**
- **Perifollicular or perilesional erythema/oedema – severity and duration of the rash 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 inflammatory creams**
- **Puffiness/redness post wrinkle treatment – typically dissipates within a couple of hours ▪Micro-crusting over some areas with very dense and coarse hair/pigmented lesions – may take 5 to 10 days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring**
- **Bruising may rarely occur and may last several days**

_____ · 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 reponse to the treatment and to 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

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 805nm or 1,060nm, 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, active acne, 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

History of livedo reticularis NO YES

History of erythema ab igne NO YES

Intake of isotretinoin within the past 6 months NO YES

Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis) NO YES:

Any known allergy? NO YES:

Any tattoo, permanent make-up and/or dysplastic nevi on requested treatment area that should be protected? NO YES

Intake of aspirin or anti-coagulants? NO YES:

Easy bruising? NO YES

Swollen legs or pain after long standing/sitting? NO YES

Previous vein surgery on requested treatment area (sclerotherapy, stripping, etc…) NO YES:

Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?) NO YES:

Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…)

Within the past 6 weeks? NO YES:

what/when?

Previous skin procedures on requested treatment area (Botox, fillers, peels, metal implants, threads, etc...)

Within the past 6 weeks? 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 LightSheer®QUATTRO™ treatments

____

Name of patient (please print) Signature of patient Date

____

Name of witness (please print) Signature of witness Date