**IADVL- Academy**

**SIG (Special Interest Group) Laser and Aesthetics 2018- 2019**

**Consent form for Acne Scar Procedure**

(Please acknowledge the source when using this consent form)

Name: Mrs./ Mr. / Ms. …………………………………………………………………………………………………………………..

Address: …………………………………………………………………………………………………………………………………

Hospital ID: ……………………. Phone Number: ……………………………………………………………………………………

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, here by authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or his trained assistant to operate on myself or on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is my \_\_\_\_\_\_\_\_\_\_\_\_\_(relation) for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**AREA to be treated includes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The aim of the surgical procedure is to replace an ugly/more apparent scar to a less apparent and aesthetically better scar.

I am aware of the following:

1. The **complications** like pain, swelling, infection, scarring, discoloration of skin, irregularity of contour of skin, allergic reaction to the suture material, delayed wound healing, hypertrophic scar, keloid formation etc. The procedure will cause bleeding, sometimes significant, which should stop within few minutes without any lasting effect when pressure is applied. The bleeding may not reach upper level of the skin and may result in bruises of the skin. The red colour will darken to purple and purple yellow and will disappear in 1-2 weeks. Some amount of pain, swelling and discomfort is expected at the site of operation. For this a course of antibiotics and painkillers will be prescribed to me. In case pain or swelling is severe I need to contact my doctor immediately.
2. The potential benefits of the proposed procedure and possible **alternate procedures**. In addition to surgery, there are other modalities like laser therapy, dermabrasion, microneedling, chemical peels etc. I have been offered the option to discuss these various therapies before opting for surgery.
3. This particular procedure may be unsuccessful due to unforeseen circumstances and **no guarantee** can be made for the successful outcomes of these procedures.
4. The need of regularity of treatments, **multiple sessions** or touch-ups and maintenance treatments in the future.
5. The **pre- and post- treatment care** and follow-ups. I am aware that avoiding movements and taking care of the recipient area is essential for optimal results. During post-operative period, I will avoid any activity which can produce tension at the operated site. I will try to keep the area dry.
6. The **cost of treatment** per sitting and the payment schedule. (I will be responsible for reimbursing the cost of the procedure as many of the procedures may not covered by insurance companies or companies).
7. The sensation of the procedure and mandatory use of **Local, Block, Topical and /or General anesthesia**. (I give consent for the anesthesia.)

I consent to the **taking of the photographs** during the course of my procedure for the purpose of proper documentation, publications, presentations and post-operative assessment.

For the **women of childbearing age**: By signing below I indicate that I am not pregnant. Furthermore, I agree to keep the doctors informed should I become pregnant during the course of the treatment.

I will inform the doctor of all current **medications** and change in the medications during the course of treatment.

I have duly parted with necessary information about my medical history regarding any bleeding disorders, treatment with blood thinning medications, allergies to local anesthetics or otherwise, history of herpes, prior procedures and any untoward events with them.

I am giving consent that if anything goes wrong during the procedure, I may be given any **emergency treatment** best suited to me, without asking for my prior permission.

I further state that, I have carefully read and understood all the information provided in this form and with a fully conscious mind, I hereby give my written consent for the said procedure along with its involved risks. **The procedure, the side effects and the risks involved have been explained to me in my native language.** I hereby **release** Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and its designated staff from liability associated with the above procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the patient/ thumb impression Signature of the Guardian (For Minors)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and relationship with the Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness 1 Witness 2