**IADVL- Academy**

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

**Consent for laser for vascular lesions**

(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\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Treatment Area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Indications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Machine Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This procedure involves using lasers of certain wavelengths to treat abnormal blood vessels by coagulating the aberrant vessels with laser energy.Indicated for treating abnormal blood vessels that are seen in conditions such as port wine stain birthmarks, strawberry hemangiomas, telangiectasia (broken capillaries of spider veins), leg veins and rosacea.

I am aware of the following:

1. The **adverse events like** pain, purpura, swelling, redness, bruising, blistering, crusting/scab formation, infection, and unforeseen complications which can last up to many months, years or permanently. There is a risk of scarring, textural and/or color changes in the skin, which can be permanent.
2. The potential benefits of the proposed procedure and possible **alternate procedures** like alternate lasers, cautery, surgical excision, z-plasty, dermabrasion and sclerotherapy has been explained to me.
3. No **guarantee**, warranty, or assurance has been made to me as to the results that may be obtained and that for maximum and optimum results, several treatment sessions may be required spaced at varying intervals. Some lesions cannot be removed completely and there is no way one can predict the final outcome and number of sittings.
4. I understand that **variable results** are seen due to the patients’ lifestyle, medical profile, age, and genetic factors.
5. The need of regularity of treatments, **multiple sessions** or touch-ups and maintenance treatments in the future.
6. The need of proper **pre- and post- treatment care**. (The instructions given should be strictly adhered to).
7. 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).
8. The sensation of the procedure and on occasion, use of topical, block, local 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. I give consent for the same.

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.

My **medical history** regarding active skin infection, impaired healing (e.g. keloid scar formers), and pregnancy.

I am giving consent that if anything goes wrong during the procedure, I may be given any **emergency treatment including alternate treatments** 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.

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

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Name and relationship with the Guardian Date

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Witness 1 Witness 2