Lumenis Spendor X treatment consent

Please read and initial each statement. Complete, underline or circle individual selection accordingly.	
	Initials
I authorize provider _____to perform SPENDOR X treatments on me for HAIR reduction/Pigmentented lesions/Skin treatments/Nail fungus /Other:_____	
I understand that there is a rare possibility of side effects or serious complications including skin burns, 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/tingling sensation which degree will vary per condition density and area sensitivity. A mild "sun-burn" sensation may follow for a couple of hours and will be reduced with application of cooling and soothing creams	
• Erythema/oedema-severity and duration will depend on the intensity of the treatment and the sensitivity of the area to be treated. This redness/swelling may be reduced with application of cooling and/or inflammatory creams	
• *Crusting*-over some dense pigmented areas-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* if your skin is prone to it over dense vasculated areas-may last several days	
I understand that recent 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 response to the treatment and 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	
I agree to review the following laser pre-treatment compliance checklist along with my medical provider and bring accurate and updated data, to the best of my knowledge	

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Natural or artificial sun exposure in the past 3-4 weeks pre-op or following 3-4 weeks post-op plan	Yes	No
Use of self-tanners or tan enhancer caps within the past 3-4 weeks pre-op plan	Yes	No
Photosensitive herbal preparations (St. John's Wort, Ginkgo Biloba, etc) or aromatherapy (essential oils) If yes:_____	Yes	No
Diseases which may be stimulated by list at 755nn and/or 1064 nm, such as history of Systemic Lupus Erythematosus or Porphyria	Yes	No
Pregnant or possibility of pregnancy, postpartum or nursing	Yes	No
Inflammatory skin conditions (dermatitis, active acne, etc)	Yes	No
Prescence or history of active cold sores or herpes simplex virus	Yes	No
HIV	Yes	No
Active cancer (currently on chemotherapy or radiation)	Yes	No
Previous skin cancer	Yes	No
Medical history of keloids	Yes	No
History of livedo reticularis	Yes	No
History of erythema ab igne	Yes	No
Intake of isotretinoin within the past 6 months	Yes	No
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	Yes	No
Any known allergy	Yes	No
Date of latest blood tests	WHEN___/_____/_____	
Any hormonal imbalances? If yes:_____	Yes	No
Hormonal or endocrine disorders (PCOS or uncontrolled diabetes)		
Any tattoo and/or dysplastic nevi on requested treatment area that should be protected		
Intake of aspirin or anti-coagulants		
Easy bruising		
Swollen legs or pian after long standing/sitting		
Previous hair removal procedures on requested treatment area (other IPL/laser, was, electrolysis, etc...) Within the past 6 weeks		
Previous skin procedures on requested treatment area (Botox, fillers, pees, etc...) If yes: _____		
List of additional current medication taken or other health conditions to be noted.		

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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 SPLENDOR X treatments.

Name of patient (please print)	Signature of patient	Date

Name of witness (please print)	signature of witness	Date