Midlands Laser Clinic

Laser Treatment Consent Form

This form is designed to give you the information you need to make an informed choice on whether or not to undergo laser treatment.

Although laser treatment is effective in most cases, no guarantees can be made that a specific patient will benefit from treatment. Some conditions will not completely disappear but will be improved. Some vascular lesions may not respond at all to this treatment.

What is Laser Treatment?

Lasers have been used for many years for the treatment of various skin conditions and vascular lesions. Lasers emit various beams of light that penetrate the skin to heat the specific target areas. The precision ensures that the surrounding tissue is hardly affected.

Lasers can be used to treat Onychomycosis (fungal toe), verrucae, warts, spider veins as well as a wide range of other conditions.

Side Effects and Possible Complications:

1. **Discomfort, soreness, warm sensation or pain.**

2. **Healing wound** – laser treatment may occasionally cause a superficial burn to the skin which may take several days to resolve. This may result in swelling, weeping, crusting or flaking of the treated area. This usually takes 5-10 days to heal but may vary depending on treatment. We recommend regular post treatment review with your practitioner in this event.

3. **Redness** – this may occur after a laser treatment and will vary on specific laser treatments and may take days to weeks to settle.

4. **Loss of pigmentation** – usually, the treated area loses pigmentation and becomes a lighter colour than the surrounding skin temporarily. This will fade over 2-4 weeks. With repeated treatment, this may take 6-8 months or longer to resolve. There is some risk of permanent pigment loss in the affected area, but this is rare.

5. **Increased pigmentation** – this may occur as a healing reaction. This is rare and usually fades over 2-6 months. In very rare cases there is some permanent increase in pigmentation but again, this is rare.

6. **Scarring** – there is a very small risk of scarring, including hypertrophic scars (enlarged scars) and rarely, keloid scars (abnormal, heavy and raised scars). To minimise this risk, it is important that you follow all post treatment instructions carefully.

7. **Eye exposure** – there is a risk of harmful eye exposure to the laser energy. Safeguards will be provided including the use of safety eyewear during the laser treatment. It is important to keep these protective glasses on at all times during treatment to protect your eyes from accidental laser exposure.

8. **The responsibility lies totally with the patient** to inform the practitioner of any medical concerns, and to disclose any prescribed medication or recreational drugs that they are using. This disclosure is **strictly confidential** under the Data Protection Act. For your own health it is vitally important that you provide the practitioner with accurate information.

9. **The tattoo removal treatment is performed at the direct request of the patient** and no responsibility is taken by the practitioner for the result of any inks either directly or indirectly causing ailments during or after the tattoo removal procedure.

10. **In the case of tattoo removal, if the procedure was not performed here, would you go elsewhere for the treatment**? Yes / No (please circle)

I have been informed of the:

1. Potential benefits and prospects of success of laser treatment
2. Reasonably anticipated consequences if the procedure is not performed
3. Risks and side effects involved in the proposed procedures.

I have been given the opportunity to ask questions and have received satisfactory answers.

Name of Treatment: ……..

I understand the necessity for the administration of a topical or local anaesthetic if appropriate.

I understand that the practice of medicine and surgery is not an exact science and that therefore no guarantee of result can be made.

I authorise the taking of photographs or films before, during and after the procedure for documentation.

I hereby authorise ……..... to perform and or assist in the proposed procedure(s) described above.

Patient's Name: **Signature:** **Date:**

I certify that I have made the disclosures referred to the above named patient and have given the patient the opportunity to ask questions.

Practitioner's Name: **Signature:** **Date:**