

# MONTAGUE EYE CENTER

## CONSENT FOR IPL TREATMENT

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

- |   | <u>Initials</u> |
|---|-----------------|
| <ul style="list-style-type: none"><li>I authorize Doctor Jennifer Lippens to perform IPL™ treatments on me in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia /<br/>Other: _____</li></ul>   | _____           |
| <ul style="list-style-type: none"><li>I understand that without eye protection, IPL applied near the eyes may cause severe ocular complications</li></ul>   | _____           |
| <ul style="list-style-type: none"><li>I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility</li></ul>  | _____           |
| <ul style="list-style-type: none"><li>I understand the below list of short-term effects and agree to follow matching guidelines:<ul style="list-style-type: none"><li>Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring</li><li>Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild “sun-burn” sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams</li><li>Reddening and swelling – severity and duration 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 anti-inflammatory creams</li><li>Bruising may rarely occur and may last up to 2 weeks</li></ul></li></ul> | _____           |
| <ul style="list-style-type: none"><li>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</li></ul>   | _____           |
| <ul style="list-style-type: none"><li>The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered</li></ul>   | _____           |
| <ul style="list-style-type: none"><li>Pre and post-care instructions have been discussed and are completely clear to me</li></ul>   | _____           |
| <ul style="list-style-type: none"><li>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</li></ul>   | _____           |
| <ul style="list-style-type: none"><li>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</li></ul>   | _____           |
| <ul style="list-style-type: none"><li>I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity</li></ul>  | _____           |
| <ul style="list-style-type: none"><li>I agree to review the following IPL™ pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge</li></ul>  | _____           |

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For Dry Eye Disease due to Meibomian Gland Dysfunction:

	Skin type of the area to be treated: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/>		
OptiLight	Ocular surgery or eyelid surgery, within 6 months prior to the first IPL session?	NO	YES
	Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL session ?	NO	YES
	Uncontrolled eye disorders affecting the ocular surface, for example active allergies ?	NO	YES
	Pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area ?	NO	YES
	Uncontrolled infections or uncontrolled immunosuppressive Diseases ?	NO	YES
	Ocular infections, within 6 months prior to the first IPL session ?	NO	YES
	Prior history of cold sores or rashes in the perioral area or in the planned treatment area that could be stimulated by light at a wavelength of 560 nm to 1200 nm, including: Herpes simplex 1 & 2, Systemic Lupus erythematosus, and porphyria ?	NO	YES
	Within 3 months prior to the first IPL session, use of photosensitive medication and/or herbs that may cause sensitivity to 560-1200 nm light exposure, including: Isotretinoin, Tetracycline, Doxycycline, and St. John's Wort ?	NO	YES
	Radiation therapy to the head or neck, within 12 months prior to the first IPL session ?	NO	YES
	Planned radiation therapy, within 8 weeks after the last IPL session	NO	YES
	Treatment with chemotherapeutic agent, within 8 weeks prior to the first IPL session ?	NO	YES
	Planned chemotherapy, within 8 weeks after the last IPL session ?	NO	YES
	History of migraines, seizures or epilepsy ?	NO	YES
	Tattoos in the planned treatment area ?	NO	YES
	Exposure to sun or artificial tanning during 3-4 weeks prior to treatment ?	NO	YES
Any remaining suntan, sunburn or artificial tanning products ?	NO	YES	

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For all other conditions (relevant for an upgraded configuration of the OptiLight device):

	Skin type of the area to be treated: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/>		
	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 400 nm to 1200 nm, 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, etc...)	NO	YES: .....
	Presence or history of active cold sores or herpes simplex virus	NO	YES
<b>HR</b>	HIV	NO	YES
<b>PL</b>	Active cancer (currently on chemotherapy or radiation)	NO	YES
<b>SR</b>	Previous skin cancer?	NO	YES
<b>VL</b>	Medical history of keloids	NO	YES
	Intake of isotretinoin within the past year	NO	YES
	Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES: .....
	Any known allergy?	NO	YES: .....
	Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	NO	YES
	List of additional current medication taken		
<b>HR</b>	Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO	YES: .....
	Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc...)	NO	YES: what/when? .....
<b>PL</b>	Any observed modification (colour, size, texture and border) on the lesion to be treated?	NO	YES: .....
<b>SR</b>	Any hair on requested treatment area that should not be removed?	NO	YES
<b>VL</b>	Age of lesion onset?		
<b>PL</b>	Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...)	NO	YES: what/when? .....
<b>SR</b>	Intake of aspirin or anti-coagulants?	NO	YES: .....
<b>VL</b>	Easy bruising?	NO	YES

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My signature certifies that I duly read and understood the content of this informed consent form, and that I gave accurate information as to my health condition. I hereby freely consent to OptiLight IPL treatments.

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Name of patient (please print)

Signature of patient

Date

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Name of witness (please print)

Signature of witness

Date