## Intense Pulse Light Therapy (IPL)

## \*The following must be removed prior to treatment\*

Make-Up Contact Lenses Perfumes Lotions Reflective Jewelry Colognes

**IPL Contraindications:** IPL treatment must **not** be used on pregnant women, people with epilepsy, people with metal, electric and acoustic prostheses within the face, irregular heartbeats, thrombophlebitis or acute phlebitis of the legs, major varices, and hypertension.

Please read and initial that you understand and consent to each of the following: <u>Initials:</u>

I authorize my doctor and/or their technicians to perform IPL treatments on me in an effort to improve rosacea, telangiectasia of the lids, lid margin edema, biofilm with or without demodex, demodex, changes in the viscosity of the natural oil from the meibomian glands.	
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.	
I understand the below list of short-term effects and agree to follow matching guidelines:	
<ul> <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 last up to 2 weeks</li> </ul>	
I understand that sun exposure or tanning in a tanning bed is not aligned with the pre and/or post care instructions and may increase the chance for complications	ı
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, such as no makeup, lotions, or perfumes on day of procedure. The use of moisturizer and sunscreen for 3 days post procedure	
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, of the eyelid/lid area, being used for medical education or publication with applied discretion and not revealing my identity	
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	

Skin type of the area to be treated: I II III IV	V	VI
Natural or artificial sun exposure in the past 3-4 weeks pre-op or plan to during the following 3-4 weeks post up	No	Yes
Use of self-tanners or tan enhancer caps within the past 3-4 weeks pre-op	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
HIV	No	Yes
Active cancer (currently on chemotherapy or radiation)	No	Yes
Previous skin cancer of the face	No	Yes
Medical history of keloids	No	Yes
Intake of isotretinoin within the past year (Retinol)	No	Yes
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	No	Yes
Any tattoo and/or pigmented lesion in the last 3 months on requested treatment area that should be protected?	No	Yes
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 (if yes, how long ago)
Any observed modification (color, size, texture and border) on the area to be treated?	No	Yes
Any hair on requested treatment area that should not be removed?	No	Yes
Lesion, and age of lesion onset	No	Yes
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc.)	No	Yes: what/when:
Intake of aspirin or anti-coagulants	No	Yes
Easy bruising	No	Yes
Any known allergy?	No	Yes what:
List any additional current medication taken:		

## CONTACT LENSES MUST BE REMOVED FOR THE TREATMENT AND CAN BE RE-INSTERTED IMMEDIATELY FOLLOWING

My signature certifies that I have clearly 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 IPL skin treatments.

Name of Patient	Signature of Patient (or person authorized to sign for patient)	Date
Name of Witness	Signature of Witness	Date