MIAMI CENTER FOR
PLASTIC SURGERY
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RETREATMENT LASER HAIR REMOVAL CONSENT FORM

PATIENT NAME: _____
(Apellido)

I have been informed of the following possible risks and complications of **LASER HAIR REMOVAL** include but are not limited to:

Initial

_____ Purpura (red-purple discoloration, bruising)

_____ Itching (hive-like response which lasts 2-3 hours to 2-3 days)

_____ Herpes simplex virus activation

_____ Infection, burns, blisters, scabbing, crusting, skin color and /or textural changes

_____ Hyperpigmentation (darkening of the skin; transient, long term or possibly permanent)

_____ Hypopigmentation (lightening of the skin; transient, long term or possibly permanent)

_____ Scarring (rare, possibly permanent)

_____ I understand that complete clearing may not be possible and will depend upon the type,age and color of the lesion.

I understand that immediately following the laser treatment redness, swelling, discomfort, bruising, and discoloration may develop at the treatment site. I understand that any discoloration may last 7-14 days and swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents. I agree to comply with instructions regarding after care of the treated area. It is important to follow after care instructions carefully to minimize the chance of incomplete healing, skin textural changes or scarring. Sun avoidance and use of a sunscreen is recommended. Tanning should be avoided completely during the duration of the treatment.

_____ I have provided my past and current medical history and medications (oral and topical that may cause photosensitivity).

_____ I am not pregnant or breast feeding (female patients).

_____ I will avoid the sun 4-6 weeks before and after treatment.

_____ I do not wear a pacemaker or defibrillator

_____ I do not have a history of photosensitive epilepsy

I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.

Contraindications to the performance of this procedure have been discussed in detail with me.
I CLEARLY HERBY ACKNOWLEDGE THAT BY PARTICIPATING IN LASER TREATMENTS, IT IS POSSIBLE THAT I MAY SUSTAIN THE COMPLICATIONS MENTIONED ABOVE AND/OR PERMANENT DAMAGE.

Patient Signature_____ Date_____

Office Use Only

Area Treated	Wavelength	Spot Size	Energy	Pulse Duration	DCD

Additional Notes: _____

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Technician: _____ Date: _____