INVISION

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

Initials

- I authorize Doctor _____ to perform fractional non-ablative laser resurfacing on my skin in an effort to improve _____ _____
- Pre and post-care instructions have been discussed and are completely clear to me. _____
- I understand that there is a rare possibility of side effects or serious complications post treatment, including pigmentary changes 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 skin responses and agree to follow matching guidelines:
  - Discomfort – during the procedure, I might experience a hot needle pricking sensation which degree will vary per my skin condition and area sensitivity. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams.
  - 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.
  - Xerosis and pruritus - within the first few days after treatment, my skin may feel itchy, tight and dry. Regular application of moisturizers helps reducing this sensation.
  - "Bronzed" appearance - within the first few days after treatment, I may develop a pinkish and/or coloured tone and discrete dry flaking. It is important I do not rub nor pick my skin which may otherwise lead to scarring. A broad spectrum (UVA/UVB) sunscreen SPF 30 or greater should be applied to the area(s) to be treated whenever exposed to the sun. _____
- 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. _____
- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered. _____
- 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 for the expected level of improvement. _____
- 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 laser pre-treatment compliance checklist below along with my Physician and bring accurate and updated data, to the best of my knowledge.

Skin type: I □ II □ III □ IV □ V □ VI □		
Recent exposure to sun in the 4-6 weeks pre-op plan, remaining suntan or artificially toned skin	NO	YES
Photosensitivity or use of photosensitive (to 1565nm) medication and/or herbal preparations	NO	YES: what/when? ……
Intake of isotretinoin within the past 6 months	NO	YES
Concurrent inflammatory skin conditions (dermatitis, active acne, rosacea, etc…)	NO	YES: what/when? ……
Presence or history of active cold sores or herpes simplex virus	NO	YES
Immune-compromised conditions	NO	YES: what? ……
History of post-inflammatory hyperpigmentation	NO	YES
Medical history of keloids	NO	YES
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES: what? ……
Multiple dysplastic nevi in area to be treated	NO	YES
Active cancer (currently on chemotherapy or radiation)	NO	YES
Previous skin cancer	NO	YES
Any tattoo and/or pigmented lesion on requested treatment area that should be protected	NO	YES
Pregnant or possibility of pregnancy, postpartum or nursing	NO	YES
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...)	NO	YES: what/when? ……
Any known allergy?	NO	YES: what? ……
List of additional current medication taken		

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 ResurFX™ laser treatment.

Name of patient (please print) Signature of patient Date

Name of witness (please print) Signature of witness Date

(1 copy Patient and 1 copy Physician for Medical Record)

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