Eyecare Center of Salem

OPTILIGHT CONSENT FORM

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

Initials

I authorize Doctor _____ to perform IPL treatments on me in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentaion / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia / Other: _____ _____

I understand that without eye protection, IPL applied near the eyes may cause severe ocular complications

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:

- 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
- 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
- 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
- Bruising may rarely occur and may last up to 2 weeks _____

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 _____

Pre and post-care instructions have been discussed and are completely clear to me _____

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 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 _____

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For Dry Eye Disease due to Meibomian Gland Dysfunction:

Skin type of the area to be treated: I ☐ II ☐ III ☐ IV ☐ V* ☐	NO	YES
Ocular surgery or eyelid surgery, within 6 months prior to the first IPL session?	☐	☐
Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL session?	☐	☐
Uncontrolled eye disorders affecting the ocular surface, for example active allergies?	☐	☐
Pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area?	☐	☐
Uncontrolled infections or uncontrolled immunosuppressive diseases?	☐	☐
Ocular infections, within 6 months prior to the first IPL session?	☐	☐
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?	☐	☐
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?	☐	☐
Radiation therapy to the head or neck, within 12 months prior to the first IPL session?	☐	☐
Planned radiation therapy, within 8 weeks after the last IPL session?	☐	☐
Treatment with chemotherapeutic agent, within 8 weeks prior to the first IPL session?	☐	☐
Planned chemotherapy, within 8 weeks after the last IPL session?	☐	☐
History of migraines, seizures or epilepsy?	☐	☐
Tattoos in the planned treatment area?	☐	☐
Exposure to sun or artificial tanning during 3-4 weeks prior to treatment?	☐	☐
Any remaining suntan, sunburn or artificial tanning products?	☐	☐

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For All Other Conditions:

		NO	YES
HR PL ST VL	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 the following 3-4 weeks post-op plan?	☐	☐
	Use of self–tanners or tan enhancer caps within the past 3-4 weeks pre-op plan?	☐	☐
	Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc…) or aromatherapy (essential oils)?	☐	☐
	Diseases which may be stimulated by light at 400 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria?	☐	☐
	Pregnant or possibility of pregnancy, postpartum or nursing?	☐	☐
	Inflammatory skin conditions (dermatitis, etc…)?	☐	☐
	Presence or history of active cold sores or herpes simplex virus?	☐	☐
	HIV?	☐	☐
	Active cancer (currently on chemotherapy or radiation)?	☐	☐
	Previous skin cancer?	☐	☐
	Medical history of keloids?	☐	☐
	Intake of isotretinoin within the past year?	☐	☐
	Medical history of Koebnerizing isomorphic diseases (e.g. vitiligo, psoriasis)?	☐	☐
	Any known allergy?	☐	☐
	Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	☐	☐
	List of additional current medication taken:		
HR	Hormonal or endocrine disorders (e.g. PCOS, uncontrolled diabetes?)	☐	☐
	Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…)	☐	☐
PL ST VL	Any observed modification (color, size, texture and border) of the lesion to be treated?	☐	☐
	Any hair on requested treatment area that should not be removed?	☐	☐
	Age of lesion onset?	☐	☐
PL ST	Previous skin procedures on requested treatment area (Botox, fillers, peels, etc…)	☐	☐
ST VL	Intake of aspirin or anti-coagulants?	☐	☐
	Easy bruising?	☐	☐

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

Name of Patient (please print)	Signature of Patient	Date

Name of Witness (please print)	Signature of Witness	Date