Fraxel® DUAL 1550/1927 Laser Treatment
Patient Consent Form

Patient Name _____ Date of Birth _____

Do not sign this form without reading and understanding it

The Fraxel DUAL 1550/1927 procedure (Fraxel) has been explained to me.
I understand this procedure involves risk to some degree.

I understand that the following are **expected side effects** of Fraxel:

Discomfort — Most people will feel some heat-related discomfort (pain) associated with treatment. This is usually temporary during the procedure and localized to the treatment area. A small number of patients have reported tenderness in the treatment area lasting several weeks.

Redness and Swelling — Laser treatment will cause redness and swelling in the treatment area. These last from several days to a few weeks, depending upon aggressiveness of treatments.

Itching — This can occur as part of the normal wound healing process or may occur as part of infection, poor wound healing or contact dermatitis.

Acne or Milia Formation — A flare-up of acne or formation of milia (tiny white bumps or small cysts on the skin) may occur. These usually resolve completely.

Herpes Simplex (cold sore) r*eactivatio*n — this can occur in those having Fraxel treatments around the mouth with a history of cold sores. This can be prevented or reduced with use of an antiviral medication before and after treatment. Please inform us if you have a history of cold sores.

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I understand that the following are **possible risks or complications** associated with Fraxel:

Bleeding; Oozing; Crusting — Aggressive treatment may cause pin point bleeding, petechiae (small red dots under the skin surface), and/or oozing. Crusting or scabbing may form if the clear fluid or blood dries.

Blisters; Burns; Scabbing — Heating in the upper layers of the skin may cause blisters or burns and subsequent scab formation. The blisters usually disappear within 2-4 days. A scab may be present after a blister forms, but will disappear with natural wound healing.

Scarring — Scarring is a possibility due to the disruption to the skin's surface and/or abnormal healing. Scars, which can be permanent, may be raised or depressed and scarring could lead to loss of pigment ("hypopigmentation") in the scarred area.

Pigment Changes — During the healing phase, the treated area may appear to be darker. This is called PIH, post inflammatory hyperpigmentation. You may have experienced this type of reaction before and noticed it with minor cuts or abrasions. PIH occurs as a part of the normal skin reaction to injury. PIH occurs more frequently with darker colored skin, after sun exposure to the treatment area, or with patients who already have a tan. To reduce the risk of PIH, the treated area must be protected from sunexposure (regular sunscreen use for 6 months after treatment). However, in some patients, increased skin pigmentation may occur even if the area has been protected from the sun. This pigmentation usually fades in 3 to 6 months.

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Hypopigmentation — In some patients who experience pigment changes, the treated area loses pigment (hypopigmentation) and becomes a lighter color than the surrounding skin. This type of reaction may also be permanent.

Infection — If blisters or bleeding are present, an infection of the wound is possible. Scarring and associated pigment changes may result from an infection.

Eye Injury — Eye irritation may result from numbing cream getting into the eyes; and eye injuries from direct laser damage. To protect your eyes, they will be covered with goggles during treatment and should remain closed during the treatment. The laser could cause direct eye injury in the absence of these precautions.

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Efficacy — Because all individuals are different, it is not possible to completely predict who will benefit from the procedure. Some patients will have very noticeable improvement, while others may have little or no improvement. A series of treatments is usually needed for maximum results.

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Contraindications — Fraxel DUAL 1550/1927 may result in abnormal wound healing in patients who are currently undergoing or have had Accutane/Epuris/Clarus treatment within the past six months, have a predisposition to keloid formation or excessive scarring.

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I am aware that other unexpected risks or complications may occur and that no guarantees or promises have been made to me concerning the results of the procedure. It has also been explained that during the proposed procedure, unforeseen conditions may be result and require additional procedures. My questions regarding this treatment, its alternatives, its complications and risks have been answered by my doctor and/or his staff.

- DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND UNDERSTAND IT.
- ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM.
- DO NOT SIGN IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

I have read this form and understand it, and I request the performance of the procedure.

_____ Date _____

Patient Signature Prior To Treatment

I have informed the patient of the available alternatives to treatment and of the potential risks and complications that may occur as a result of this treatment

_____ Date _____

Patient Signature on day of Treatment

_____ Date _____

Signature of Certified Aesthetic Laser Therapist / Nurse / Medical Director (Please Circle which)