PiQo 4 Laser Consent

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

*Physician Perfroming Procedure*_____*David West M.D.*_____

Initials

- I authorize the above referenced Physician to perform PiQo4™ laser procedure on me in an effort to reduce the appearance of my Tattoos (older than 6 months) or Other:..... _____
- I consent to the administration of advisable topical / injectable Lidocaine and I have been informed of the potential risks and complication of the Lidocaine used _____
- 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 that sun exposure or tanning of any sort is not recommended with the pre and/or post-care instructions and may increase the chance for complications _____
- I understand the below list of short-term effects and skin responses. I agree that I fully understand these responses to the procedure:
  - Pain – during the procedure, the laser pulse may feel like a rubber band snapping the skin. The power used by the machine to reach certain pigments will have varying degrees of discomfort to the patient. To reduce discomfort, numbing and/or cool air might be used
  - Ash-white discoloration and skin elevation – immediately after laser exposure, a slightly elevated, white discoloration with or without the presence of scattered bleeding is often observed on dark tattoos. Very quickly this phenomenon is replaced by redness and swelling that might be minimized via cooling and which may last 3 to 7 days _____
  - Crusting – multiple pinpoint crusts may appear. Antibiotic ointments or healing ointments should be applied. It is important that I do not rub nor pick my skin which may otherwise lead to scarring
  - Red or purple spots – broken capillary blood vessels may lead to transient “mini- bruising”. Sun avoidance is essential in that case
  - Allergic reactions – an immediate or delayed allergic reaction may develop due to some broken tattoo pigments or drug reactions. In that case, I need to contact my treating Physician for instructions
  - Infection and inflammation – in some cases, inflammatory conditions may develop. If the treated area becomes itchy, presents oozing, spreading redness and/or is full of pus, I need to contact my treating Physician for instructions

- I understand that tattoo clearance may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment or how many treatments I may need _____
- I understand that the procedure may not be effective on certain pigments and that multiple treatments are required _____
- I consent to photographs being used for medical education or publication of the specific area and not revealing my identity. _____
- 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. _____

Pregnant or possibility of pregnancy, postpartum or nursing	NO□	YES □
Natural or artificial sun exposure in the past 4-6 weeks	NO□	YES □
Application of self – tanners within the past 2-3 weeks	NO□	YES □
Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc…) or aromatherapy	NO□	YES □ Pls specify: .....
Inflammatory skin conditions (dermatitis, active acne, etc...)	NO□	YES □ Pls specify: .....
Presence or history of active cold sores or herpes simplex virus	NO□	YES □
HIV	NO□	YES □
Infection, skin laceration or scarring on treatment site	NO□	YES □
Active cancer (currently on chemotherapy or radiation)	NO□	YES □
Previous skin cancer?	NO□	YES □
Medical history of keloids or poor wound healing	NO□	YES □
Intake of isotretinoin within the past year	NO□	YES □
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO□	YES □ Pls specify: .....
Immunocompromised conditions (for example: uncontrolled diabetes)	NO□	YES □ Pls specify: .....
Bleeding coagulopathies or usage of anticoagulants	NO□	YES □ Pls specify: .....
Gold salts (as part of rheumatoid arthritis treatment)	NO□	YES □
Presence of double tattoos (camouflage tattoo over an undesired first tattoo)	NO□	YES □
Any known allergy?	NO□	YES □ Pls specify: .....
Injections, fillers or implants on treatment site within the past 3 months	NO□	YES □ Pls specify: .....
List of additional current medication taken and/or other considerations:		

The procedure as well as potential benefits, risks, and alternatives have been explained to me by my Physician and I have had all my related questions satisfactorily answer by my Physician. **Initials**:_____

My signature certifies that I have duly read and understand the content of this informed consent form, and that I have provided the accurate information as to my medical history and health condition. I hereby freely consent to PiQo4™ laser procedure and accept the risks and possible complications of such treatment.

Name of patient (please print)	Signature of patient	Date and Time
Name of witness (please print)	Signature of witness	Date
Name of physician (please print)	Signature of physician	Date