	579 E. Fort Union Blvd, Midvale, UT 84047 *Office: 801-255-8500* *Fax: 801-255-2334* *www.abundoeyecare.net*

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

Initials

- I authorize Dr. Abundo to perform Optilight IPL™ on me in an effort to improve my dry eye disease. ________
- 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 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™/laser pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge ________

	Skin type of the area to be treated: I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐		
HR PL SR VL	Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan	NO____	YES____
	Use of self–tanners or tan enhancer caps within the past 3-4 weeks pre-op plan	NO____	YES____
	Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc...) or aromatherapy (essential oils)	NO____	YES____
	Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria	NO____	YES____
	Pregnant or possibility of pregnancy, postpartum or nursing	NO____	YES____
	Inflammatory skin conditions (dermatitis, active acne, etc...)	NO____	YES____
	Presence or history of active cold sores or herpes simplex virus	NO____	YES____
	HIV	NO____	YES____
	Active cancer (currently on chemotherapy or radiation)	NO____	YES____
	Previous skin cancer?	NO____	YES____
	Medical history of keloids	NO____	YES____
	Intake of isotretinoin within the past year	NO____	YES____
	Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO____	YES____
	Any known allergy?	NO____	YES____
	Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	NO____	YES____
HR	Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO____	YES____
	Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc...) If yes, what type of treatment and when:_______________________________________	NO____	YES____
PL SR VL	Any observed modification (colour, size, texture and border) on the lesion to be treated?	NO____	YES____
	Any hair on requested treatment area that should not be removed?	NO____	YES____
	Age of lesion onset?		
PL SR	Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...) If yes, what treatment and when:_____________________________	NO____	YES____
SR VL	Intake of aspirin or anti-coagulants?	NO____	YES____
	Easy bruising?	NO____	YES____
VL	Swollen legs or pain after long standing/sitting?	NO____	YES____
	Previous vein surgery on requested treatment area (sclerotherapy, stripping, etc...) If yes, what surgery and when:_________________	NO____	YES____

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 Optilight IPL treatment.

Name of patient (please print) Signature of patient Date

Name of witness (please print) Signature of witness Date