**Laser Consultation and Consent Form**

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| --- | --- | --- | --- |
| **Client Personal Information** | | | |
| **Name** |  | **Date of Birth** |  |
| **Address** |  | **Mobile Phone** |  |
| **City** |  | **Home/ Workphone** |  |
| **Post Code** |  | **Gender** |  |
| **Referred By** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Skin Type Assessment** | | | |
| **Fitzpatrick skin type** | **I II III IV V VI** | **Ethnicity** |  |
| **Last exposure to UV** | **(Sun or solarium)** | | |
| **Passive tan?** | **YES / NO** | **Self-tanning lotion?** | **YES / NO** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Hair Assessment** | | | |
| **Areas to be treated** |  | | |
| **Hair density** | **Sparse/Medium/Dense** | **Hair Thickness** | **Fine/Medium/Coarse** |
| **Hair colour** |  | **Eye colour** |  |

The GMax Pro is a Laser device that produces an intense but gentle burst of light. This light is absorbed by and causes selective heating of certain cells. I agree to having \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ treatment on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre and post treatment instructions, and individual response to treatment.

I understand that there is a possibility of short term effects such as reddening, swelling, mild burning, temporary bruising and temporary discoloration of the skin. There is also the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

My eyes will be covered with laser specific safety eyewear or an opaque material to protect them the intense light. My eyes will be closed and I will NOT attempt to remove the eye protection during my treatment.

**Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Medical History** | | | |
| Pacemaker/ Defibrillator |  | Active skin infections (e.g. psoriasis, eczema, tinea) |  |
| Metal Implants |  | Skin disorders ( e.g. keloids, abnormal wound healing) |  |
| Current/Past History of skin cancers/ malignant moles |  | History of bleeding disorders |  |
| Severe concurrent medical conditions |  | Use of herbal medication that induces photosensitivity |  |
| Pregnant and or breastfeeding |  | Facial laser resurfacing/ deep chemical peeling in the last 3 months |  |
| Impaired immune system |  | Needle epilation, waxing or tweezing in the last 6 weeks |  |
| Diseased stimulated by light (e.g. Lupus, porphyria, Epilepsy) |  | Tattoos or permanent makeup |  |
| Diseased stimulated by heat ( e.g. Herpes Simplex) |  | Tanned skin |  |
| Endocrine disorders ( e.g. diabetes, PCO) |  | Saphenous Insufficiency |  |
| Surgical Procedures |  | Injections/Fillers |  |
| **List any medications taken** |  | | |
| **List any allergies** |  | | |
| **Detail any medical conditions** |  | | |
| **Other considerations** |  | | |

**I confirm that I have informed the staff regarding any current or past medical condition, disease, or medication taken and that the information I have provided on my consent is true and correct.**

**I consent to the taking of photographs and authorise their anonymous use for the purposes of medical audit, education and promotion.**

**I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent for and aftercare instructions,**

**Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**