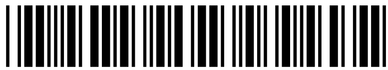


NOSCAN

CoxHealth

CoxHealth Med Spa

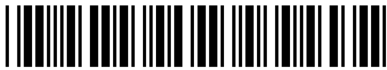
Name: ________________________
Age: _____ DOB: ___/___/_______
MRN: ____________________
(or Patient Sticker Here)

Consent Form for PiQo4 Treatment

Please read each statement.

- I authorize my physician to perform laser on me for treatments of skin resurfacing, benign pigmented lesions or tattoos (older than 6 months) / Other: ____ .
- I consent to the administration of advisable topical / injectable anesthesia and I have been informed on potential risks and complication of the anesthesia 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 pigment 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 aligned 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 and agree to follow matching guidelines:
  - Pain – during the procedure, the laser pulse may feel like a rubber band snapping the skin which level will vary per pigment intensity. To reduce discomfort, numbing and/or cold packs and/or cool air might be used.
  - Ash-white discoloration and epidermal elevation – immediately after laser exposure, a slightly elevated, white discoloration with or without the presence of punctuate bleeding is often observed on tattoos and pigmentation. Very quickly this phenomenon is being replaced by redness, swelling and scabs of variable intensity and duration.
  - Crusting – multiple pinpoint crusts may appear. Antibiotic ointments or healing ointments should be applied. It is important 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 purulent, I need to contact my treating Physician for instructions.
  - For any other reaction not listed herein and occurring in the days following the treatment, I will refer to my treating Physician for additional counselling and guidelines.
- I understand that pigment/tattoo clearance and skin resurfacing outcome may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment.
- 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 with applied discretion and not revealing my identity.

Skin type: I □ / II □ / III □ / IV □ / V □ / VI □		
Pregnant or possibility of pregnancy, postpartum or nursing	NO □	YES □
Natural or artificial sun exposure in the past 4-6 weeks pre-op plan	NO □	YES □
Application of self – tanners within the past 2-3 weeks pre-op plan	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: ....



NOSCAN

CoxHealth
CoxHealth Med Spa

Name: ______________________
Age: _____ DOB: ___/___/_______
MRN: ____________________
(or Patient Sticker Here)

Consent Form for PiQo4 Treatment

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:		

My signature certifies that I have duly read and understood the content of this informed consent form, and I have given accurate information as to my health condition(s). Ihereby freely consent to PiQO4 treatment.

____

Patient/Legal Representative (please print) Signature Date

____

Name of witness (please print) Signature Date