NOSCAN

CoxHealth
CoxHealth Med Spa

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

Consent Form for SPLENDOR X Treatment

Please read each statement.

- I authorize my physician to perform treatments on me for Hair Reduction / Pigmented Lesions / Vascular Lesions / Skin Treatment / Nail Fungus / Warts / Other: _____.
- I understand there is a rare possibility of side effects or serious complications including skin burns, 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:
  - Discomfort – during the procedure and shortly after, I might experience an itching/ tingling sensation which degree will vary per condition density and area sensitivity. A mild "sun-burn" sensation may follow for a couple of hours and will be reduced with application of cooling and soothing creams.
  - Erythema/oedema – severity and duration will depend on the intensity of the treatment and the sensitivity of the area to be treated. This redness/swelling may be reduced with application of cooling and/or inflammatory creams.
  - Crusting over some dense pigmented areas – may take five (5) to ten (10) days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring.
  - Bruising if your skin is prone to it or over dense vasculated areas – may last several days.
- I understand that recent 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 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 □		
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	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 755nm and/or 1064nm, 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
History of livedo reticularis	NO	YES

NOSCAN

CoxHealth
CoxHealth Med Spa

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

Consent Form for SPLENDOR X Treatment

History of erythema ab igne	NO	YES
Intake of isotretinoin within the past 6 months	NO	YES
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES:
Any known allergy?	NO	YES:
Date of latest blood tests	WHEN:	
Any hormonal imbalance?	NO	YES: which levels? …….
Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO	YES:
Any tattoo and/or dysplastic nevi on requested treatment area that should be protected?	NO	YES
Intake of aspirin or anti-coagulants?	NO	YES:
Easy bruising?	NO	YES
Swollen legs or pain after long standing/sitting?	NO	YES
Previous hair removal procedures on requested treatment area (other IPL / laser, wax, electrolysis, etc…)	NO	YES: what/when? ……..
Within the past 6 weeks?	NO	YES
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc…)	NO	YES: what/when? ……..
List of additional current medication taken or other health conditions to be noted		

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). I hereby freely consent to SPLENDOR X treatment.

Patient/Legal Representative (please print)	Signature	Date
Name of witness (please print)	Signature	Date