



Dr. Krishna Khatri Optometry PC
 5935 Malden Road, Unit 1 LaSalle, ON N9H 1S6
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M22™ IPL Treatment Informed Consent and Medical History

PATIENT INFORMATION			
Patient Name		Date	
Date of Birth		Age	
Occupation			
Address			
City		Province	
Postal Code		Phone	
EMERGENCY CONTACT			
Name		Phone	

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

	<u>Initials</u>
<ul style="list-style-type: none"> I authorize the staff from _____ Clinic to perform IPL™ treatments on me in an effort to improve Dry Eye Disease / MGD/ Other: _____ 	
<ul style="list-style-type: none"> 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 	
<ul style="list-style-type: none"> I understand the below list of short-term effects and agree to follow matching guidelines: <ul style="list-style-type: none"> 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 may occur and should resolve within 5 days – 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 anti-inflammatory creams Bruising may rarely occur and may last up to 2 weeks – there is an increased risk of this occurring if you have taken aspirin or aspirin containing products or blood thinning medications. You can cover with makeup while it is fading. Pigment changes – During the healing process the area may become lighter or darker, this is usually temporary but in some instances it can be permanent 	



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<ul style="list-style-type: none"> 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, a sunblock with a minimum of 30 SPF is required post treatment 	
<ul style="list-style-type: none"> The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered 	
<ul style="list-style-type: none"> Pre and post-care instructions have been discussed and are completely clear to me 	
<ul style="list-style-type: none"> 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 	
<ul style="list-style-type: none"> I agree to review the following IPL™ pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge 	

MEDICAL HISTORY

Which skin type best describes you?	
I Always burns, never tans	<input type="checkbox"/>
II Always burns, sometimes tans	<input type="checkbox"/>
III Sometimes burns, always tans	<input type="checkbox"/>
IV Rarely burns, always tans	<input type="checkbox"/>
V Brown, moderately pigmented skin	<input type="checkbox"/>
VI Black Skin	<input type="checkbox"/>
Are you currently under the care of a physician	Yes <input type="checkbox"/> No <input type="checkbox"/>
Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan	Yes <input type="checkbox"/> No <input type="checkbox"/>
Use of self-tanners or tan enhancer caps within the past 3-4 weeks pre-op plan	Yes <input type="checkbox"/> No <input type="checkbox"/>
Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc...) or aromatherapy (essential oils)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diseases which may be stimulated by light at 400 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure moderately intense heat or infrared irradiation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pregnant or possibility of pregnancy, postpartum or nursing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Inflammatory skin conditions (dermatites, etc...)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a history of an autoimmune disease, in which the blood vessels are constricted, or narrowed resulting in mottled discoloration on large areas of the leg or arms	Yes <input type="checkbox"/> No <input type="checkbox"/>
Presence or history of active cold sores or herpes simplex virus	Yes <input type="checkbox"/> No <input type="checkbox"/>
HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>
Active cancer (currently on chemotherapy or radiation)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Previous skin cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medical history of keloids	Yes <input type="checkbox"/> No <input type="checkbox"/>

