

## **Information and Consent Form for Tetra Pro Treatment**

This consent form includes general descriptions of various dermatological laser treatments, including possible benefits and risks that may occur as a result of these treatments. Your doctor or nurse will describe and discuss the specific details of your procedure with you and answer your questions.

Please read the applicable sections of this consent form carefully. This form may contain words that are unfamiliar to you. Please ask your doctor or one of his staff to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

### **PROCEDURE**

#### **Tetra Pro Fractional Treatment for Age Related Skin Changes, Pigmentation and Scarring.**

Ablative laser treatment is a technique for eliminating blemished areas from the skin and improving lines and irregularities that result from ageing process and sun damage. The Tetra Pro fractional ablative laser is a system designed to penetrate into the lower layers of the skin in small areas leaving normal healthy skin in- between allowing a rapid recovery.

A local or topical application of anesthetic may be applied prior to treatment to reduce discomfort caused by the laser. Photographs of the treatment area may be taken for your medical chart and future comparison. Multiple treatments are usually necessary to achieve complete satisfaction.

Benefits of this treatment include the possible reduction or elimination of unsightly pigmented lesion like solar spots or uneven skin colour. Lines and wrinkles may be improved and unevenness due to acne scarring improved.

Possible risks or discomforts (side effects) may include pain, burning, blister formation, stinging sensation, infection, pigmentary changes including decrease or increase in skin colour at the site of treatment, scar formation, laser induced "cold-sore-like" blistering, skin eruptions known as "herpetic" skin eruptions at the site of treatment and poor cosmetic outcome.

In order to ensure a positive outcome with laser treatment, reducing any risk of possible side effects, the patient must strictly follow the pre and post operative protocols.

### **GENERAL RISKS**

Eye injury due to use of the laser is a risk to the patient and to the physician. The risks are almost completely eliminated with the correct use of proper eyewear.

## PATIENT CONSENT FORM FOR TREATMENT

- This policy, information, initial assessment and the consent form includes general descriptions of various dermatological laser treatments, including possible benefits and risks that may occur as a result of these treatments.
- Please read the applicable sections of this consent form carefully. This form may contain words that are unfamiliar to you. In case of invalid clients, an authorised persons' signature would be required, or the clinic manager may take a view and not proceed with any treatment.
- Ask your laser nurse or practitioner or one of the clinic staff to explain any words or information that you do not clearly understand.
- You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

My signature below constitutes my acknowledge that

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date of Birth)

I am a competent, consenting adult or 18 years of age (or my parent or legal guardian is giving consent on my behalf), and further, that I:

- have received all the information I desire concerning my procedure. Y /N
- have read and understand the information provided in this form Y /N
- have had my procedure adequately explained to me by the practitioner Y /N
- consent to photographs of the treatment area Y /N
- understand all pre and post treatment recommendations Y /N
- assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure Y /N
- have the right to consent to or refuse any proposed procedure at any time prior to treatment Y /N
- to notify the clinic of my medical history changes Y /N
- agree / do not agree for the clinic to inform my GP of this treatment Y /N
- nominate \_\_\_\_\_ to give consent on my behalf Y /N
- consent to, and authorise \_\_\_\_\_  
(Print Operator / Nurse / Clinician's Name)

to perform the laser treatment for: \_\_\_\_\_  
(Print Name of Laser Procedure to Be Carried Out)

\_\_\_\_\_  
Signature (Patient, or signature of parent/guardian)

\_\_\_\_\_  
Date

Printed name of signatory: \_\_\_\_\_

If signed by other person, indicate relationship: \_\_\_\_\_

Tetra Pro Treatment Plan for \_\_\_\_\_

| Area to be treated | Estimated individual treatment time | Estimated treatments required | Estimated total treatment time for series | Frequency                  |
|--------------------|-------------------------------------|-------------------------------|-------------------------------------------|----------------------------|
|                    |                                     |                               |                                           |                            |
|                    |                                     |                               |                                           |                            |
|                    |                                     |                               |                                           |                            |
| Treatment Summary  |                                     |                               |                                           | Treatment plan recommended |
| <b>TOTALS</b>      |                                     |                               |                                           |                            |

### Pre-treatment instructions:

- Apply SPF30 sun block to treatment areas that are exposed to the sun. You may improve your results and reduce the risk of possible side effects by limiting exposure to the sun, tanning beds or tanning lotions for four weeks prior to treatment.
- Apply the topical cream *[ put the name of the suggested cream ]* for inhibiting melanin production every day for four weeks before the treatment.  
*[Highly recommended for darker and Asian skin types]*
- Start the antiviral prophylaxis 6 days before the treatment if you have a positive anamnesis of herpes virus infections history.
- Start the antiviral prophylaxis 2 days before the treatment if you don't have previous experience of herpes infections.
- It is recommended to continue the antiviral drugs at routine doses for 5-15 days after the intervention.  
*[The practitioner may consider prescribing antibiotic drugs, starting 6 or 1 days before the treatment (according to the patient anamnesis) and continuing for 7-8 days after the procedure.]*
- Inform us if you have taken in the past months or are planning to begin taking incompatible drugs as:
  - Anticoagulants *[as acetylsalicylic acid, heparin, etc],*
  - Retinoids *[as isotretinoin - Accutane, etc],*
  - Photo-sensitizers *[as tetracycline (antibiotic), naproxen (NSAD), auranofin (antirheumatic), estrogens and progestins (oral contraceptive), cloroquine (antimalarial), etc.]**[Suspending the administration according to the specific drug so that its effect is expired before the treatment]*
- Inform us if you have performed any surgical treatment (as lifting, etc.) in the past 6 months.
- Inform us if there has been any change in your medical history since your last visit (skin disorders, herpes virus infection, etc..)

### Prior to treatment, Do Not:

- Perform exfoliation treatment (as peeling with Retin-A, glycolic acid, etc.) for 10 days prior to treatment.

**Post treatment instructions** [ *we suggest open type medication*]:

- The treated area should be gently washed with tepid water and mild soap.
- Cold packs compression with sterile gauze and physiological solution has to be applied regularly to reduce redness and swelling.
- Apply the cream or ointment if provided in a thin layer, after cleaning and the cold compression.

**This procedure has to be performed 3-4 times per day until the clinical healing is observed (4-7 days).**

**After this time:**

- Apply a normal skin-care moisturizer and SPF50 sun block protection on all treated areas that may be exposed to the sun. [*Apply the sun block for 2-5 months according to the skin phototype and the environmental conditions*].
- Please call us at the first sign of persistent pain or blistering.

**Post treatment, Do Not:**

- Have a shower during the 24 hours after the treatment (avoid hot water on the treated area until healing is complete).
- Expose the treated area to sun.
- Perform topical exfoliation for at least 4 weeks.

**Post treatment expectations:**

- Redness for two to seven days, depending on the type of treatment
- The area should settle within four to ten days post treatment

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{Practice/MD Name here}

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Patient

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Date

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Date

## Tetra Pro Patient Case History

|                             |  |  |  |           |  |
|-----------------------------|--|--|--|-----------|--|
| Patient Name                |  |  |  | Skin Type |  |
| Date                        |  |  |  |           |  |
| Treatment #                 |  |  |  |           |  |
| Treatment Site              |  |  |  |           |  |
| Type of Condition/lesion    |  |  |  |           |  |
| Change in Medial History    |  |  |  |           |  |
| Power (W)                   |  |  |  |           |  |
| Spacing                     |  |  |  |           |  |
| Dwell Time                  |  |  |  |           |  |
| Stacking (number)           |  |  |  |           |  |
| Emission Mode               |  |  |  |           |  |
| Spray Y/N?                  |  |  |  |           |  |
| Anesthetic used             |  |  |  |           |  |
| Erythema                    |  |  |  |           |  |
| Oedema                      |  |  |  |           |  |
| Blistering                  |  |  |  |           |  |
| Discoloration               |  |  |  |           |  |
| Discomfort                  |  |  |  |           |  |
| Infection Problems          |  |  |  |           |  |
| Cold Compress Used          |  |  |  |           |  |
| Cream or Ointment           |  |  |  |           |  |
| Port Treatment Instructions |  |  |  |           |  |
| Antiviral Prophylaxis       |  |  |  |           |  |
| Antibiotic Prophylaxis      |  |  |  |           |  |
| Time Required               |  |  |  |           |  |
| Comments                    |  |  |  |           |  |
| Practitioner                |  |  |  |           |  |

