Sparta Optometry
Compassionate Care
Excellence in Service

OptiLight Consent Form

Please read and initial each statement.

INITIALS

- I authorize Dr. David R. Harkema, OD and staff to perform IPL treatments on me in an effort to improve Dyschromia / Hyperpigmentation / Haemangioma / Angioma / Rosacea / Telangiectasia
    - Others: _____ _____
- 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. _____
- I understand the below list of short-term effects and agree to matching guidelines:
    - Flaking of pigmented lesions - crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring.
    - 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 - 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 inflammatory creams.
    - Bruising may rarely occur and may last up to 2 weeks.
- 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. _____
- 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 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/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. _____

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For Dry Eye Disease due to Meibomian Gland Dysfunction: (Please Circle Section Accordingly)

	Skin type of the area to be treated: I □ II □ III □ IV □ V □		
OptiLight	Ocular surgery or eyelid surgery, within 6 months prior to the first IPL session?	NO	YES
	Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL session?	NO	YES
	Uncontrolled eye disorders affecting the ocular surface, for example active allergies?	NO	YES
	Pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area?	NO	YES
	Uncontrolled infections or uncontrolled immunosuppressive Diseases?	NO	YES
	Ocular infections, within 6 months prior to the first IPL session?	NO	YES
	Prior history of cold sores or rashes in the perioral area or in the planned treatment area that could be stimulated by light at a wavelength of 560 nm to 1200 nm, including: Herpes simplex 1 & 2, Systemic Lupus erythematosus, and porphyria?	NO	YES
	Within 3 months prior to the first IPL session, use of photosensitive medication and/or herbs that may cause sensitivity to 560-1200 nm light exposure, including: Isotretinoin, Tetracycline, Doxycycline, and St. John's Wort?	NO	YES
	Radiation therapy to the head or neck, within 12 months prior to the first IPL session?	NO	YES
	Planned radiation therapy, within 8 weeks after the last IPL session Treatment with chemotherapeutic agent, within 8 weeks prior to the first IPL session?	NO	YES
	Planned chemotherapy, within 8 weeks after the last IPL session?	NO	YES
	History of migraines, seizures or epilepsy?	NO	YES
	Tattoos in the planned treatment area?	NO	YES
	Exposure to sun or artificial tanning during 3-4 weeks prior to Treatment?	NO	YES
	Any remaining suntan, sunburn or artificial tanning products?	NO	YES

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For All Other Conditions: (Please Circle Section Accordingly)

HR: Hair Removal **PL:** Pigmented Lesions **SR:** Skin Treatments **VL**: Vascular Lesions

	Skin type of the area to be treated: I □ II □ III □ IV □ V □		
HR PL SR VL	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 plan?	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 400 nm to 1200 nm, such as the history of Systemic Lupus Erythematosus or Porphyria?	NO	YES
	Pregnant or possibility of pregnancy, postpartum or nursing?	NO	YES
	Inflammatory skin conditions (dermatitis, 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
	Intake of isotretinoin within the past year?	NO	YES
	Medical history of Koebnerization Isomorphic Diseases (vitiligo, psoriasis)?	NO	YES: ……
	Any known allergies?	NO	YES
	Any tattoo and/or pigmented lesion on the requested treatment area that should be protected?	NO	YES
HR	Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)?	NO	YES: ……
	Previous hair removal procedures on requested treatment areas (other IPL/laser, wax, electrolysis, etc…)?	NO	YES: (what/when) .....
PL SR VL	Any observed modification (color, size, texture and border) on the lesion to be treated?	NO	YES: ……..
	Any hair on the requested treatment area that should not be removed?	NO	YES
	Age of lesion onset?	NO	YES
PL SR	Previous skin procedures on requested treatment areas (Botox, fillers, peels, etc...)?	NO	YES: (what/when) .....
SR VL	Intake of aspirin or anti-coagulants?	NO	YES
	Easy bruising?	NO	YES

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My signature certifies that I duly read and understood the content of this informed consent form, and that I gave the accurate information as to my health condition. I hereby freely consent to OptiLight IPL treatments.

Name of Patient (please print)	**Signature of Patient**	**Date**

Sparta Optometry,PC	**Signature**	**Date**