IADVL- ACADEMY- SPECIAL INTEREST GROUP- LASERS AND AESTHETICS

CONSENT FORM FOR CHEMICAL PEELING:

Hospital/Clinic: _____

Patient's Name: _____ Age_____

Contact No.: _____

Address: _____

Type of peel used:----------

I understand that chemical peeling is the application of chemical agent to the skin which causes controlled alteration of a part or entire epidermis with or without the deeper dermis leading to exfoliation, removal of superficial lesions and followed by formation of a new healthy skin.

No guarantee, warranty, or assurance has been made to me as to the results that may be obtained and that for maximum and optimum results, several treatment sessions may be required spaced at varying intervals. Some lesions cannot be removed completely and there is no way one can predict the final outcome and number of sittings.

I was also informed about the other alternative methods as well as their benefits and disadvantages. I understand that for ideal results, this procedure can be combined with microneedling, PRP, laser, etc.

I am fully aware of the possible side effects and risks involved in this procedure. I am also aware that this particular procedure may not always be successful and no guarantee can be made for successful outcome of such procedure.

I understand that there may be some degree of discomfort, stinging, pin prick sensation, warmth, burning or itching at the time or after the procedure. It may cause my skin to appear pink and flaky like moderate sunburn and it may take a week or more before the skin returns to its normal appearance. However, some patients react differently.

I understand there is rarely a flare up of acne like lesions or reactivation of herpes.There is a risk of scarring,textual and/or color changes in the skin, which can be permanent.

Some of the pigmented lesions are sensitive to sunlight and there are chances of recurrence of the lesions even after complete clearance.

Topical, local or general anesthesia is required in few patients. I am ready to take the appropriate form of anesthesia.

I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however my name or identity will not be disclosed and complete confidentiality will be maintained.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of chemical peel treatment.

Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.

I also agree to comply with the recommended aftercare instructions.

I hereby release Dr. and its designated staff from liability associated with the above procedure.

My questions regarding the procedure have been answered satisfactorily.

I authorize Dr. and his/her designated staff to perform chemical peel treatment on my body.

The payment and fee structure is informed to me. I am ready to pay per sitting or package basis. [Package if opted for includes minimum number of sittings and I have to pay accordingly if more sittings are required]

SIGNATURE OF PATIENT/THUMB IMPRESSION

SIGNATURE OF PARENTS /GUARDIAN (FOR MINORS) DATE:

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NAME AND RELATIONSHIP IF SIGNED BY OTHER THAN PARENT

WITNESS: DATE:

NAME_____ SIGNATURE_____

DATE: _____

SIGNATURE OF DOCTOR----------DATE----------
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TRANSLATED IN PATIENTS LANGUAGE BY----------