

Patient's Name :-	
Patient ID	
Age:	Gender: male/female
Date:	Location:

INFORMED CONSENT FOR FRACTIONAL CO2 LASER

MACHINE USED-

TREATMENT AREA

I. _____, (the patient) or representative of patient _____), have (please tick the correct option above and below).

- Read
- Been explained this consent form in _____ (name of language) which I fully understand, and understood the information provided about _____ Full name of procedure) given below in this consent form.

Brief description of procedure

Fractional CO2 laser is an ablative fractional laser in which micro beams of light injure small fractions of the skin leaving behind areas of untreated skin which helps in quick recovery and improvement in texture of skin and scarring. Multiple sessions are required based on the indications and severity of the problem. The improvement may not be immediate and the skin usually keeps improving till 3 months to 1 year after a session.

Intended benefits

Fractional Co2 laser is used in an effort to improve acne scars, traumatic scars, burn scars, surgical scars, photo ageing and improvement in skin texture, wrinkles and fine lines.

I understand that all procedures carry certain risks. The potential risks and complications from the procedure are:

1. Pain. The stinging or burning sensation from the laser can produce a moderate amount of discomfort. An anesthetic cream, oral and injectable pain relievers and anti-anxiety medications will typically be used to minimize discomfort.
2. Redness: redness resembling a sunburn can occur in treated area. The redness will typically subside in 1 to 6 weeks, but could last longer.
3. Swelling: Treatment may cause swelling which subsides in 1 to 2 weeks and can be minimized with application of cool water compresses.

5. Skin darkening: Darkening of the skin rarely occurs in the treated areas and will usually fade within 1 to 6 months. This reaction is more common when treated areas are exposed to the sun. It is extremely important to protect the treated area from sun exposure with a hat and sunscreen for 6 weeks after treatment and carefully adhere to all post-treatment instructions.
6. Skin lightening: Laser treatment can result in loss of pigmentation where the treated area becomes a lighter color than the surrounding skin. It usually re-pigment in 1 to 6 months, but in rare cases could be permanent.
7. Blisters or scabs: Blistering is uncommon but can develop with treatment. Blisters will go away within 2 to 5 days and may be followed by a scab. The scab will disappear during the natural wound healing process of the skin. During this time, the area should not be manipulated or picked, which can lead to scarring.
8. Infection: Swelling, crusting, pain, or fever could indicate an infection or reactivation of cold sores or fever blisters. This may require use of topical or oral antibiotics and/or antiviral agents.
9. Acneiform eruptions: Breakouts from acne have been reported to occur after treatment with laser resurfacing. If this occurs, topical or oral antibiotics may be required.
10. Scarring: There is a risk of skin scarring, including abnormal raised and/or depressed scars with any resurfacing procedure. Careful adherence to all advised postoperative instructions will help reduce the possibility of this occurrence.
11. Lesion persistence or failure to respond: Some skin conditions may not improve or go away completely despite the best efforts made by the doctor. No guarantees can be made regarding any individual's response to treatment with laser resurfacing.
12. Additional side effects: There are risks associated with any procedure. Since it is impossible to state every risk or complication that may occur as a result of treatment, the possible risks and complications listed here may be incomplete. There may be risks or complications associated with this treatment that are not yet reported in the literature.

PREGNANCY AND NURSING MOTHERS: Laser treatment is not recommended for pregnant women or nursing mothers.. The patient should keep the staff informed should she become pregnant during the course of treatment.

The treatment is contraindicated in patients currently taking anti-coagulants, active skin infection, compromised immune system, impaired healing (e.g. keloid scar formers), pregnancy, and pacemaker.

I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like other laser treatments, intense pulsed light therapy, dermabrasion, chemical peels, tissue filler products, botulinim toxin (Botox and others), topical bleaching agents, topical retinoid therapy, surgical acne scar treatment etc.

I am now aware of the intended benefits, possible risks & complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient and I declare that no

guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful procedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure and understand that it is not possible to list all possible risks and complications of any procedure.

I also understand that sometimes a planned procedure may need to be postponed or cancelled if patients clinical condition demands or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequences, by submitting the withdrawal in writing.

I understand that if medical exigencies demand, further or alternative procedural measures may need to be carried out and in such case there may be difference in the planned and actual procedure.

I am now also aware that during the course of this procedure, the doctor will be assisted by medical and paramedical team, and that the doctor may seek consultation/assistance from relevant specialists if the need arises.

I agree to observing, photography (Still/video/televising) of the procedure (including my diagnosis /reports pathology, radiology, etc)for academic /medical/medico-legal purposes , provided my identity is not revealed by such acts. I also agree to my clinical details being shared for scientific publications if my identity is not disclosed.

I am also aware of the expected course after the procedure and the post procedural care to be taken .

COST AND PAYMENT POLICY:

I have been explained about the cost of each laser session which is Rs_____

I am going to pay per session / package basis. Package if opted for includes minimum number of sessions and I have to pay accordingly if any additional sessions or treatments are required.

I declare that I have received & fully understood the information provided in this consent form, that I have given an opportunity to ask questions relating to my alignment, the procedure being performed, its risks, consequences, alternatives, potential; complications and intended benefits and recovery and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

For the above mentioned operation (s)/procedures(s) that I have been made aware of, I give my consent voluntarily to Dr. (Name of doctor performing the procedure) for carrying out the said procedure on [] myself or [] my above named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

I, above named patient, named patients representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature/thumb impression	Name
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Patient		
Surrogate/Guardian (if applicable#)		(Write name relationship with patient
Reason for surrogate Consent	Patient is unable to give consent because	

*Right hand the males & left hand for Female #only if patient is a minor or unable to give consent

Signed by the above on __/__/____ at __:__ AM /PM

I, the undersigned doctor, have explained the nature, potential risks and complications intended benefits, expected post-procedure cause and possible alternatives to the planned procedure, to the patient / patient Representative. I am confident he / she has understood the information fully as described in this document.

Consent obtained by: