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

INFORMED CONSENT FOR LASER HAIR REDUCTION

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 ofprocedure:

Laser hair reduction involves using a non invasive laser device for long term reduction of facial or body hair. This procedure requires more than one treatment session.

Even after multiple sittings, 100% reduction [hair free skin] is not possible. The hair will reduce treatment in numbers and thickness.

Maintenance treatments may be required after completion of treatment.

The total number of treatment sessions may vary among individuals. Exact number of session cannot be predicted. Patients with darker skin may require more number of treatment sessions and may be more prone to adverse effects.

Hair shafts may be expelled out during the 2-3 weeks following treatment and may mimic the appearance of regrowing hair. These may be left to fall out, or they may simply be shaved.

If a patient develops growth in areas in distant regions other than the region treated, it could be due to underlying detectable or undetectable hormonal problem and if those areas are also to be covered by treatment, patient will have to bear the cost of treatment.

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

1. **Short term effects** may include reddening, swelling, bumps, mild burning, temporary bruising or blistering. Hyperpigmentation (browning of skin) and Hypopigmentation (lightening of skin), although rare, may occur. These conditions usually resolve within 3 – 6 months, but permanent color change is a rare risk, less than 1%. Avoiding sun exposure before and after treatment reduces the risk of color change.
2. **Infection** following treatment is quite unusual, but bacterial, fungal and viral infections can occur. Should any type of skin infections occur, additional skin treatments or medical antibiotics may be necessary.
3. **Allergic reactions**, although very rare, may occur. Local skin allergies to topical preparations, tape, or preservatives used in cosmetics can occur.
4. However slight, there is a **risk of scarring.**
5. *Increased hair growth in or around the treated area* is a very rare consequence of Laser Hair Removal. The scientific reason of this paradoxical regrowth is not known. However these hairs can also be reduced with same laser.

Alternatives:

I understand that there are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing, and plucking or no treatment at all and that I have the right to refuse treatment.

COST AND PAYMENT POLICY:

I have been explained about the cost of each 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 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 .

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
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: ……………………………