The Atlantis
DRY EYE CLINIC

LeAnn J Mandese, OD

 I authorize Doctor Mandese to perform IPL™ treatments on me in an effort to improve Ocular Surface Disease/Meibomian Gland Dysfunction/ Dry Eye/ Rosacea / Telangiectasia

Other: _____

☐ 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 follow 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 are 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 and 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

☐ I agree to review the following IPL™ Pre & Post Treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge.

Skin type of the area to be treated: I □ II □ III □ IV □ V □ VI □ **(please check box that coordinates with Skin Assesment)**

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 515 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria
NO_____YES_____
Pregnant or possibility of pregnancy, postpartum or nursing
NO_____YES_____
Inflammatory skin conditions (dermatitis, active acne, 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 Koebnerizing isomorphic diseases (vitiligo, psoriasis)
NO_____YES_____
Any known allergy?
NO_____YES_____ if yes allergic to _____
Any tattoo and/or pigmented lesion on requested treatment area that should be protected?
NO_____YES_____ please explain_____

PATIENT NAME (Please Print)_____

PATIENT SIGNATURE_____

DATE_____

(FOR OFFICE USE ONLY)

WITNESS SIGNATURE_____

DATE_____