Illuminate Me

PATIENT INFORMED CONSENT FORM FOR THE TREATMENT OF VEINS

Client Name: _____

I hereby authorise Leanne Doré to remove or lighten the appearance of dilated superficial veins on the face and legs.

The procedure involves using laser to coagulate the vessels and it is possible the result will be minimal or not help at all. It is not possible to make every vein disappear.

The following points have been discussed with me:

- The potential benefit of the proposed procedure.
- The possible alternative procedures.
- The probability of success.
- The most likely complications and risks involved with proposed procedure and subsequent healing period including, but not limited to, infection, scarring, blistering, crusting and pigmentary changes.
- Post treatment instructions.

I am aware of the possible experiences/risks with laser treatment.

- **DISCOMFORT:** Some discomfort may be experience during the treatment.
- **WOUND HEALING:** Any laser treatment can result in swelling, blistering, crusting or flaking of the treated area, which may require up to 1-3 weeks to heal.
- **BRUISING/SWELLING/INFECTION:** With some laser treatments bruising may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare.
- **PIGMENT CHANGES:** There is a slight possibility that the area can become either hypo-pigmented or hyper-pigmented.
- **SCARRING:** Scarring is a rare occurrence but is a possibility when the skins surface is disrupted. To minimise the chances of scarring, it is important that you follow the post-treatment instructions carefully.
- **EYE EXPOSURE:** Protective eye-wear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

ACKNOWLEDGMENT

By my signature below, I acknowledge that I have read and fully understand the contents of this informed consent for Treatment of Veins, and that I have had all my questions answered to my satisfaction by Leanne Doré.

Signature-Patient or Guardian

Print Name/Relationship **Date**

Signature-Witness

Print Name **Date**