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Please read and initial each statement. Complete, underline or circle individual selection accordingly.

- I authorize Doctor _____ to perform IPL™ treatments on me in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia /
  Other:
  _____

- I understand that without eye protection, IPL applied near the eyes may cause severe ocular complications _____

- 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 anti-inflammatory creams _____

- Bruising may rarely occur and may last up to 2 weeks _____

- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered _____

- 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 _____

- 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-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge _____

For Dry Eye Disease due to Meibomian Gland Dysfunction and all other conditions (relevant for an upgraded configuration of the OptiLight device):

Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Ocular surgery or eyelid surgery, within 6 months prior to the first IPL session?	NO	YES
	Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL session ?	NO	YES
	Uncontrolled eye disorders affecting the ocular surface, for example active allergies ?	NO	YES
	Pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area ?	NO	YES
	Uncontrolled infections or uncontrolled immunosuppressive Diseases ?	NO	YES
	Ocular infections, within 6 months prior to the first IPL session ?	NO	YES
	Prior history of cold sores or rashes in the perioral area or in the planned treatment area that could be stimulated by light at a wavelength of 560 nm to 1200 nm, including: Herpes simplex 1 & 2, Systemic Lupus erythematosus, and porphyria ?	NO	YES

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Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Within 3 months prior to the first IPL session, use of photosensitive medication and/or herbs that may cause sensitivity to 560-1200 nm light exposure, including: Isotretinoin (Accutane), Tetracycline, Doxycycline, and St. John's Wort?	NO	YES
	Radiation therapy to the head or neck, within 12 months prior to the first IPL session ?	NO	YES
	Planned radiation therapy, within 8 weeks after the last IPL session?	NO	YES
	Treatment with chemotherapeutic agent, within 8 weeks prior to the first IPL session ?	NO	YES
	Planned chemotherapy, within 8 weeks after the last IPL session ?	NO	YES
	History of migraines, seizures or epilepsy ?	NO	YES
	Tattoos in the planned treatment area ?	NO	YES
	Exposure to sun or artificial tanning during 3-4 weeks prior to treatment ?	NO	YES
	Any remaining suntan, sunburn or artificial tanning products ?	NO	YES
	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 2 weeks pre-op plan?	NO	YES
	Use of any products containing Retin-A, retinol, benzoyl peroxide, glycolic/salicyclic acids with the past week prior to treatment?	NO	YES

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Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc...) or aromatherapy (essential oils)?	NO	YES
	Diseases which may be stimulated by light at 400 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, etc…)?	NO	YES
	Presence or history of active cold sores or herpes simplex virus?	NO	YES
	Active cancer (currently on chemotherapy or radiation)?	NO	YES
	HIV?	NO	YES
	Previous skin cancer?	NO	YES
	Medical history of keloids?	NO	YES
	Intake of isotretinoin (Accutane) within the past year?	NO	YES
	Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)?	NO	YES
	Any known allergy?	NO	YES Please list:

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Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	NO	YES
	List of additional current medication taken	NO	YES
	Hormonal or endocrine disorders (PCOS or uncontrolled diabetes)?	NO	YES
	Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…)?	NO	YES Please list:
	Any observed modification (colour, size, texture and border) on the lesion to be treated?	NO	YES
	Any hair on requested treatment area that should not be removed?	NO	YES
	Previous skin procedures on requested treatment area (Botox, fillers, peels, etc…)	NO	YES Please list:

Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Botox within the previous 2 weeks or planned within two weeks after treatment?	NO	YES
	Intake of aspirin or anti-coagulants?	NO	YES
	Easy bruising?	NO	YES

My signature certifies that I duly read and understood the content of this informed consent form, and that I gave the accurate information as to my health condition. I hereby freely consent to OptiLight IPL treatments

_____

Name of patient (please print)

_____ _____

Signature of patient Date

_____ _____

Signature of witness Date

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