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LeAnn J Mandese, OD

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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 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.

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 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

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 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.

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 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.

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 Bruising may rarely occur and may last up to 2 weeks.

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 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

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

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 Pre and post-care instructions have been discussed and are completely clear to me

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 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

Skin type of the area to be treated: I □ II □ III □ IV □ V □ VI □

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: ……………….……………..

Any tattoo and/or pigmented lesion on requested treatment area that should be protected?

NO

YES

Name of patient (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Witness

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date