ROSE MEDICAL
AESTHETICS

INFORMED CONSENT FORM DIOLAZE/DIOLAZEXL HAIR REMOVAL

Personal Information	
Name:	Date of Birth:
Address:	Email:
Cell phone:	

Heath Questionnaire:	
Existing or recent Illness	Details:
Hospitalization/Surgery	Details:
Medication Intolerance	Details:
Aesthetic procedures in the treatment	Details:

Medical History – Please inform doctor/technician prior to treatment if you have any of the following conditions that may make you unsuitable for LASER Hair Removal treatments.

- Pregnancy or nursing
- Under 18 years of age (unless there is parents consent)
- Pacemaker or internal defibrillator or any electronic Implant such as glucose monitor
- Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance
- Current or history of cancer, especially skin cancer, or pre-malignant moles
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications
- Severe concurrent conditions such as cancer, cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases
- A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area (prophylactic treatment may be given)
- Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin
- History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry, cracked, ulcerated, infected and fragile skin
- Tattoos, permanent make-up, pigmented lesions (to be kept)
- Any medical condition that might impair skin healing
- Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction
- Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing
- Use of Isotretinoin (Accutane) within 6 months prior to treatment

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with DIOLAZE/DIOLAZEXL technology. If you have any questions before your treatment, please feel free to ask.

• I hereby authorize _____ and/or such assistants as may be selected to perform the DIOLAZE/DIOLAZEXL procedure.
• The physician obtained my medical history and found me eligible for treatment
• I have received the following information about the technology:

- DIOLAZE/DIOLAZEXL is a non-invasive technology that utilizes Diode laser, for hair removal with highest
- speed, the best skin cooling system for hairs of dark blond-black color
- No complete clearance is guaranteed
- Treatment requires a number of sessions
- Exact number of sessions is individual
- There may be some discomfort and transient redness and/or swelling associated with treatment
- There is a small risk of adverse reactions

• I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
• I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
• I understand that I have to comply with treatment schedule, otherwise results may be compromised.
• I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.
• I understand that not everyone is a candidate for this treatment and results may vary therefore, there is no guarantee as to the results that may be obtained

- The procedures to be used to treat my conditions have been explained to me

Patient Initials: _____. Physician/Nurse Practitioner Initials: _____

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. Any questions I may have asked have been answered to my satisfaction.
3. I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for scientific or marketing purposes without disclosing my identity, not exposing my face

_____ _____
Patient Signature Date Physician/APRN Signature

_____ _____
Patient Name (Print) Date Physician/APRN Name (Print)