## CONSENT FORM for Hair Reduction with the Chromolite IPL System

Intense Pulsed Light treatment is a method of treating unwanted hair. Unwanted hair may be caused by medical conditions such as hirsuitism, hypertrichosis and can occur naturally in some people. Treatments using the Chromolite system will not cure any medical conditions causing unwanted hair.

The purpose of the treatment is to achieve cosmetic improvements by reducing hair growth by using Intense Pulsed Light to destroy hair follicles.

I hereby authorise Solas Dermatology and Laser Clinic to treat me using the Chromolite IPL system for the reduction of my unwanted hair. I understand that the treatment results are not always 100% reduction of unwanted hair and that multiple treatments are necessary based on the unique growth cycle of hair. IPL with the Chromolite works best in people with pale skin and dark hairs.

I understand that the wearing of protective eyewear is important during this treatment and agree that I shall wear the eyewear supplied by the clinic until I am told it is safe to remove them.

I agree to follow the clinic instructions regarding avoiding UV Light exposure from the sun or sunbeds for one month before, during and after my treatment and understand that not heeding these instructions may result in a delay in my treatment programme or side effects.

I agree to follow the post treatment recommendations advised by the clinic in order to ensure the best possible results. I understand that excessive heat should be avoided for 48 hours and that exposure to the sun and sunbeds must be avoided for at least 4 weeks after the treatment and a sunblock of SPF 30 or greater must be used on the exposed skin areas. Otherwise it is possible that blotchy skin pigmentation might occur. I have been informed of the possible side effects of treatment, which includes temporary redness, sensations of heat and possible bruising or blistering and understand how and why these might occur and wish to proceed with treatment and will not hold the clinic responsible should I suffer any of these side effects.

I certify that all information that the clinic has requested of me of a medical/health nature is correct and that it is my responsibility to inform the clinic should any of this information change.

I have read the patient information leaflet on the Chromolite IPL System for permanent hair reduction and fully understand the treatment and possible side effects.

CLIENT SIGNATURE: _____ DATE: _____

OPERATOR SIGNATURE: _____DATE:_____