KERRY SKIN CLINIC
SKIN, HAIR + NAILS SPECIALISTS

Dr David Buckley
FRCGP, DP Dermatology
35 Ashe Street, Tralee, Co Kerry
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Consent form for Nlite Laser

Patient Name: _____ Date: _____

I understand the treatment to be performed using the Nlite-V laser. It has been explained to me that this treatment is considered a cosmetic procedure, and that I am responsible for all costs associated with this procedure.

It has been explained to me that when treating fine lines, wrinkles, active acne or acne scars there is a small risk of temporary redness, bruising and swelling of the area treated and I will properly carry out any aftercare instructions given to me by the laser operator to help reduce these effects.

I understand that darker skin types (Fitzpatrick type IV and above) have an increased risk of transient bruising that may last longer than that seen on the lighter skin types.

I understand that when treating vascular lesions such as red veins in the face I will have bruising which may last one – two weeks.

I confirm that all medical information and questions answered during consultation is correct and that should any of this information change at any point during my treatment time with this clinic, that it is my responsibility to make the clinic aware at the earliest opportunity.

Due to the nature of the laser light I understand that I will wear the supplied laser safety eyewear throughout the entire procedure until I am instructed to remove them by the laser operator.

I am aware that this procedure may in some cases require a number of medical treatments to achieve the desired result.

I am aware that Dr Buckley may use photographs taken of me for research and educational reasons, but under such circumstances identifying features such as my eyes will be obscured, thus ensuring I am not recognised.

I understand the treatment protocol and accept the risks to undergo this procedure and any questions that I asked have been answered satisfactorily.

The Nlite laser is **not** suitable for clients who;

- Are pregnant
- Are prone to keloid formation
- Have a history of poor wound healing
- Are taking medications which creates light sensitivity
- Are taking certain anti-seizure medication for epilepsy
- Are taking Roaccutane tablets and for six months after finishing Roaccutane.

I confirm that I was made aware of the pre-treatment requirements and have observed these as requested by the clinic. If I have failed to observe these requirements I will make the clinic aware of this.

My signature certifies that I understand the goal, limitations, alternative treatments and possible complications of Nlite laser treatment, and that I wish to proceed with the procedure.

_____ _____

Patient's Signature **Date**

_____ _____

Clinic Representative's Signature **Date**

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For more information:

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