

**LASER SKIN RESURFACING CONSENT**

---

**Patient Name****Date**

**Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.**

I have been informed that I have the following condition(s): \_\_\_\_\_

The procedure(s) to treat my condition(s) has/have been described to me as laser skin resurfacing of: \_\_\_\_\_

I have been told of the following treatment options, and the risks and benefits of each have been explained:

No Treatment  
Chemical Peel  
Dermabrasion  
Surgical Excision  
Face Lift, Eyelid Surgery, etc.  
Other \_\_\_\_\_

- \_\_\_\_\_ 1. Laser skin resurfacing is a process by which laser light is applied to the skin of the face in an attempt to change the appearance of lines, wrinkles, skin blemishes, scars and certain other localized skin conditions. Laser skin resurfacing will neither stop the aging process nor totally eliminate wrinkles. The final result of treatment may not be apparent for several months. Future treatment may be necessary, depending upon the success of this initial treatment.
- \_\_\_\_\_ 2. Treated areas will have a reddish appearance that will persist for several weeks or longer. At the junction between treated and untreated areas, a different skin color or blotching may occur. The texture of the skin may be permanently altered. Deep areas of skin wrinkling may be minimized or softened, but not eliminated. Areas of deep skin scarring (usually from acne) may require additional resurfacing treatment. The risk of infection is rare, but should it occur, topical and/or systemic antibiotic therapy may be necessary.
- \_\_\_\_\_ 3. Laser skin resurfacing usually causes some discomfort and swelling. Oozing typically occurs and the area may become covered with a crust which will normally separate within a few weeks. A skin dressing may be applied to aid in healing. If no dressing is used, it will be necessary to clean the resurfaced area 4-5 times daily and to keep the area covered with prescribed medications or ointments. Failure to do so may have negative effects on healing and the final result of surgery.
- \_\_\_\_\_ 4. The color of the treated areas become darker than the surrounding skin is the most common side effect. This is called hyper-pigmentation. Certain medications may be prescribed or recommended to help minimize this effect. Hypo-pigmentation (lightening of the skin color) is a rare complication. Both of these pigment complications usually fade in 6-12 months; however, they may be permanent. **Please inform your doctor if you have used Accutane(r), Tegison(r), or any other medications prescribed by your physician or dermatologist during the past two years. It is also very important to advise your doctor if you have ever had cold sores or other blister lesions on your face.**
- \_\_\_\_\_ 5. Small whitish bumps, called milia, may occur. They may require local treatment or medication to help them clear.

- \_\_\_\_\_6. Scarring, although rare, is a possible complication. The scars may be hypertrophic scars, which are thickened scars, and/or keloid scars, which are abnormal, raised scars which may extend beyond the limits of the original scar.
- \_\_\_\_\_7. Ectropion, an outward turning of the eyelids, may occur with laser treatment. It is usually temporary, but may require further treatment, including additional surgery. Laser energy can cause eye injury, including blindness. It is important to keep your eyes closed during laser surgery.

**ADDITIONAL INFORMATION**

- \_\_\_\_\_8. This is elective, cosmetic surgery and I understand that results may vary due to individual patient differences. It is possible that my skin condition may worsen and that selective re-treatment may be required. I realize there can be no guarantee that the proposed treatment will be curative (healing) or meet all aesthetic (sense of beauty) expectations.
- \_\_\_\_\_9. I have provided a full and truthful health and social history, including drug, alcohol and tobacco use. I understand that withholding information may delay healing and jeopardize the planned goals of surgery. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that lack of cooperation can increase risks and complications.
- \_\_\_\_\_10. If any unforeseen condition should arise during surgery that may call for additional or different treatment from that planned, I authorize my doctor to use professional judgment to provide appropriate care.
- \_\_\_\_\_11. I agree to avoid direct sunlight for two (2) months after treatment and to use sun block of at least SPF 30 for 6-12 months thereafter. I also agree to decrease alcohol and tobacco use as much as possible, recognizing their negative effect on healing.
- \_\_\_\_\_12. I consent to the taking of photographs, video or audio recordings and agree to be interviewed for medical, scientific, or educational purposes. Filming or photographing an operation may include my face and may reveal my identity.

**INFORMATION FOR FEMALE PATIENTS**

- \_\_\_\_\_1. I have informed my doctor about my use of birth control pills. I have been advised that antibiotics and other medications may neutralize the preventive effect of birth control pills and may result in conception and pregnancy. I agree to consult with my physician to initiate alternative forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return solely to the use of birth control pills.
- \_\_\_\_\_2. I understand that I am not a candidate for laser surgery if I am pregnant, might be pregnant, or am nursing a child.

**CONSENT**

I certify that I have had an opportunity to read this entire consent, that all blanks were filled in before my signing, and that all my questions were answered to my satisfaction. I also certify that I speak, read and write English. I also agree to the taking of photographs/video for scientific or educational purposes. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

---

Patients or Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Witness' Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_