FRANKLIN FAMILY EYE CARE

Informed Consent
Lumenis IPL Treatment

Name: _____ Date of Birth: _____

Please read and complete initial each statement. Complete each individual selection accordingly.

I authorize Dr. Jon Franklin to perform IPL™ treatments on me in an effort to improve (please check all that apply) Initials

- O Dry Eye
- O Rosacea
- O Hair Reduction
- O Hyperpigmentation
- O Angioma
- O Hemangioma
- O Telangiectasia
- O Dyschromia
- O Other: _____ _____

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. _____

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. It is important not to manipulate or pick which may otherwise lead to scarring.
- *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.
- *Reddening and swelling* - severity and duration depend on the intensity of thetreatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or anti-inflammatory creams.
- *Bruising* may rarely occur and may last up to 2 weeks. _____

I understand that sun exposure or tanning of any sort (including both natural and artificial tanning beds) is not aligned with the pre and/or post-care instructions and may increase the chance for complications. _____

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

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

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. _____

	Office Use: 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 400 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, etc...)	NO	YES:
	Presence or history of: active cold sores or herpes simplex virus	NO	YES
HR	HIV	NO	YES
PL	Active cancer (currently on chemotherapy or radiation)	NO	YES
SR	Previous skin cancer?	NO	YES
VL	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
	List of additional current medication taken		
HR	Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO	YES:
	Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…)	NO	YES: what/when?
PL	Any observed modification (colour, size, texture and border) on the lesion to be treated?	NO	YES:
SR	Any hair on requested treatment area that should not be removed?	NO	YES
VL	Age of lesion onset?		
PL **SR**	Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...)	NO	YES: what/when?
SR	Intake of aspirin or anti-coagulants?	NO	YES:
VL	Easy bruising?	NO	YES

My signature certifies that I have duly read and understood the content of this informed consent form and gave the accurate information as to my health condition. I hereby freely consent to M22™ IPL skin treatments

Signature: _____ **Date:** _____

FRANKLIN FAMILY EYE CARE

Skin Typing Assessment Quiz

Patient Name: _____ **Date of Birth:** _____

Please indicate the number that best answers each question below. Total each section in the provided space.

Genetic Predisposition						**Report Score**
Score	0	1	2	3	4	
What is the color of your eyes?	Light blue, grey, green	Blue, grey, or green	Blue	Dark brown	Brownish black	_____
What is the natural color of your hair?	Sandy red	Blonde	Chestnut, dark blond	Dark brown	Black	_____
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	_____
Do you have freckles on nonexposed areas?	Many	Several	Few	Incidental	None	_____

Total score for genetic predisposition: _____

Reaction to sun exposure						**Report Score**
Score	0	1	2	3	4	
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns	_____
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly	_____
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	_____
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	_____

Total score for reaction to sun exposure: _____

Tanning habits						**Report Score**
Score	0	1	2	3	4	
When did you last expose your body to sun (or artificial sunlamp/self-tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago	_____
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always	_____

***Total score for tanning habits*:** _____

Add up the total scores for each of the three sections for your: ***Skin Type Score:*** _____

Your signature below indicates that you have answered the above to the best of your knowledge.

Patient Signature: _____ **Date:** _____

Updated 09/17/2021

FRANKLIN FAMILY EYE CARE

SPEED Survey of Dry Eye Assessment

Name: _____ **Date of Birth:** _____

Please check all symptoms you have:

- O Dryness
- O Grittiness/ scratchiness
- O Burning/ stinging
- O Watering
- O Eye Fatigue
- O Stringy mucus in Eyes
- O Redness
- O Itching
- O Fluctuating vision
- O Contact lens discomfort
- O Light sensitivity

Yes / No Do you have Rosacea or redness in your cheeks?

Yes / No Do you use eye drops for lubrication?

Yes / No Do you get flushed after exercise or drinking alcohol?

What is the ***frequency*** of your symptoms?

0: Never 1: Sometimes 2: Often 3: Constant

	0	1	2	3
Dryness, grittiness, or scratchiness				
Soreness or irritation				
Burning or watering				
Eyes feel tired				

What is the ***severity*** of your symptoms?

0: No Problems 1: Tolerable- Not perfect, but not uncomfortable 2: Uncomfortable- Irritating, but does not interfere with my day
3: Bothersome- Irritating, and interferes with my day 4: Intolerable- Unable to perform my daily tasks

	0	1	2	3	4
Dryness, grittiness, or scratchiness					
Soreness or irritation					
Burning or watering					
Eyes feel tired					

For office use only	SPEED score: (Frequency + Severity/28)	Diagnosis Code(s)
Total:		

Updated 09/17/2021