



Dermatology *Partners*, Inc.

PATIENT CONSENT FORM FOR GENTLELASE LASER HAIR REMOVAL

NAME: _____

I authorize Dr. _____ to perform Candela GentleLASE laser therapy on me.

The Candela GentleLASE is a device that produces an intense but gentle burst of light that fragments and removes the hair with selective destruction without harming the surrounding tissue. To protect my eyes from the intense light, I will have my eyes covered with an opaque material or wear laser protective glasses.

I have been informed that scarring, blistering, purpura, hypopigmentation or hyperpigmentation are possible risks and complications of this procedure. Usually, if these occur, they are temporary and can resolve in a few days or weeks.

For the best results, I have been informed that multiple treatments will be necessary.

Anesthesia is usually not necessary as this laser also uses a cooling device that delivers a spray to the surface of the skin to reduce discomfort, when the laser pulse is delivered. If additional anesthesia is needed, all options will be discussed with me.

I consent to the taking of photographs during the course of my laser therapy for the purpose of medical education.

I understand that immediately following the laser treatment, the treated area will appear as a red discoloration and have edema (swelling) which may last up to two hours or longer. The redness and erythema may last up to 2-3 days. The treated area will feel like a sunburn for a few hours after treatment.

Antibiotic ointment may be used for a few days after treatment or possible aloe vera gel will be necessary. Improper care of the treated area may increase the chance of scarring or skin textural changes. This has been discussed with me.

I have read and understood all information presented to me before signing this consent.

Patient Signature (or Guardian)

Date

Witness

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