SÉRONA
Beauty & Laser Clinic
www.seronabeautylongford.ie

CLIENT LASER CONSULTATION AND CONSENT FORM

SERONA BEAUTY & LASER CLINIC

TREATMENT: _____ DATE: _____

PERSONAL DETAILS

NAME: _____ DOB: _____ TELEPHONE: _____

EMAIL ADDRESS: _____

ADDRESS: _____

DOCTOR'S NAME: _____ TELEPHONE: _____

CONSULTATION QUESTIONNAIRE

HAVE YOU USED ANY ALPHA HYDROXY ACID (AHA) OR GLYCOLIC PRODUCTS IN THE PAST 48-72 HOURS? _____

ARE YOU USING RETIN-A, RENOVA OR ACCUTANE (AN ORAL FORM OF RETIN-A)? _____

ARE YOU USING ANY SKIN THINNING PRODUCTS OR DRUGS? _____

ARE YOU PREGNANT OR NURSING?_____

ARE YOU EXPOSED TO THE SUN OR SUNBED? _____

DO YOU SUFFER FROM EPILEPSY OR DIABETES? _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?_____

ARE THERE OTHER MEDICAL CONDITIONS OR ISSUES THAT YOUR THERAPIST SHOULD BE AWARE OF? _____

HAVE YOU EVER BEEN TREATED FOR CANCER? IF YES, WHEN AND WHAT TYPES OF THERAPIES WERE USED?_____

DO YOU WEAR CONTACT LENSES?_____

DO YOU HAVE ANY ALLERGIES?_____

DO YOU HAVE ANY SKIN CONDITIONS SUCH AS PSORIASIS?_____

DO YOU HAVE ANY RECENT SCARS (UNDER 6 MONTHS OLD) OR SUFFER FROM KELOID SCARRING?_____

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CONSENT

I HEREBY AUTHORIZE AND DIRECT SERONA BEAUTY TO PERFORM LASER HAIR REMOVAL ON ME.

I UNDERSTAND THAT THIS PROCEDURE WORKS ON THE GROWING HAIRS AND NOT ON DORMANT HAIRS. FOR THIS REASON, COMPLETE DESTRUCTION OF ALL HAIR FOLLICLES FROM ANY ONE TREATMENT IS UNLIKELY, AND I UNDERSTAND THAT I WILL REQUIRE SEVERAL CONSECUTIVE TREATMENTS TO OBTAIN A SIGNIFICANT, LONG-TERM REDUCTION OF HAIR GROWTH. I ALSO UNDERSTAND SOME PEOPLE MAY NOT EXPERIENCE COMPLETE HAIR LOSS EVEN WITH MULTIPLE LASER PROCEDURES AND SOME PEOPLE MAY REQUIRE MORE TREATMENTS THAN THE INITIAL SERIES. I ALSO UNDERSTAND THAT I WILL NEED MAINTENANCE TREATMENTS TO KEEP THE GROWTH AWAY.

THE FOLLOWING POINTS HAVE BEEN DISCUSSED WITH ME:

- THE POSSIBLE COMPLICATIONS/RISKS INVOLVED WITH THE PROPOSED PROCEDURE.
- POST TREATMENT INSTRUCTIONS.

CLIENTS SIGNATURE *THERAPISTS SIGNATURE*

_____ _____

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CONSENT

I AM AWARE OF THE FOLLOWING POSSIBLE EXPERIENCES/RISKS WITH THE LASER SURGERY:

- DISCOMFORT- SOME DISCOMFORT MAY BE EXPERIENCED DURING LASER TREATMENT.
- WOUND HEALING- LASER PROCEDURES CAN RESULT IN SWELLING, BLISTERING, CRUSTING, OR FLAKING OF THE TREATED AREAS
- BRUISING/SWELLING/INFECTIN- WITH SOME LASERS, BRUISING OF THE TREATED AREA MAY OCCUR.
WHENEVER A SKIN PROCEDURE IS PERFORMED.
- PIGMENT CHANGES (SKIN COLOR)- DURING THE HEALING PROCESS, THERE IS A SLIGHT POSSIBILITY THAT THE
TREATED AREA CAN BECOME EITHER LIGHTER OR DARKER IN COLOR COMPARED TO THE SURROUNDING SKIN
- SCARRING- SCARRING IS A RARE OCCURRENCE, BUT IT IS A POSSIBILITY
- EYE EXPOSURE- PROTECTIVE EYEWEAR (SHIELDS) WILL BE PROVIDED.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS CONSENT FORM FOR LASER HAIR REMOVAL TREATMENT

CLIENTS SIGNATURE *THERAPISTS SIGNATURE*

_____ _____

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