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PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

CONSENT FOR PHOTODERM® VASCULIGHT™ TREATMENT

A. CONSENT FOR PROCEDURE

1. I authorize _____ to perform the following procedure(s):
PHOTODERM® VASCULIGHT™ TREATMENT

INDICATE LOCATION AND LATERALITY, RIGHT OR LEFT, IF APPROPRIATE

I understand that I may need urgent procedures that were unanticipated. I consent to the performance of any additional procedures determined during my original procedure to be in my interests and where delay might cause additional harm.

I understand that other qualified practitioners, including residents (doctors who have finished medical school and are getting more training), may be chosen to do or help with procedures. These practitioners may perform significant surgical tasks including: opening and closing incisions, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues. All qualified practitioners will only perform tasks that are within their scopes of practice and for which they have been granted clinical privileges. Residents will only perform all or parts of the procedures under the supervision of my doctor.

2. I understand my diagnosis/condition to be: _____

3. I have been told about what results to expect, which includes information about the chances for the expected results and about problems that might occur during recuperation. I know that results cannot be guaranteed. Experience in this area indicates that those people who tend to sunburn rather than tan, usually obtain good results on the first and subsequent visits. On the other hand, those who tan more easily tend to have more variation in their results. Some patients in this category will experience partial results and some will experience no improvement at all.

I understand that the treatment by the Photoderm Vasculight system involves payment and the fee structure has been fully explained to me.

4. I understand that the Photoderm Vasculight treatment is intended to treat benign vascular and pigmented lesions and that clinical results may vary in different skin types. I have been told about and understand the risks and benefits of the procedure(s) listed above. I understand that there are risks for all kinds of procedures. These risks, which can scarring, permanent discoloration and short term effects such as reddening, mild burning, temporary bruising, and temporary discoloration of the skin. They may result in paralysis, cardiac arrest, brain damage, and/or death. Other risks for this procedure may include:

5. I understand the alternatives to the proposed procedure to be: **INJECTIONS, ELECTRIC NEEDLE TREATMENT, THE RISKS OF THESE ALTERNATIVES HAVE BEEN EXPLAINED TO ME.**

6. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be present, providing consultation or performing checks on the equipment.

7. I understand that photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes.

8. I understand that any tissues or parts removed during my procedure may be disposed of by the hospital or used for any lawful purpose including education and research.

9. Consent for Serial Procedures (when applicable)
I consent to the above as a series of the same treatment over period of time from ___/___/___ to ___/___/___.

(CONTINUED ON NEXT PAGE)



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B. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE PRINTED NAME DATE TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:		
<input type="checkbox"/> 1. Agent Named in Advance Directive	<input type="checkbox"/> 4. Adult Child	<input type="checkbox"/> 7. Other Blood Relative
<input type="checkbox"/> 2. Guardian	<input type="checkbox"/> 5. Parent	<input type="checkbox"/> 8. Other* _____
<input type="checkbox"/> 3. Husband/Wife	<input type="checkbox"/> 6. Adult Brother/Sister	
FOR MINOR PATIENTS:		
<input type="checkbox"/> 1. Parents	<input type="checkbox"/> 2. Guardian or Legal Custodian	<input type="checkbox"/> 3. Authorized person for child in out-of-home placement

* Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.

C. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT PRINTED NAME PIC # DATE TIME

SIGNATURE OF WITNESS (OPTIONAL)
REQUIRED FOR TELEPHONE CONSENTS PRINTED NAME DATE TIME

D. INTERPRETER ATTESTATION:

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID # PRINTED NAME DATE TIME