GentleYAG ™ Patient Informed Consent

I authorize _____ to perform Candela **GentleYAG** laser therapy
for Laser Hair removal _____
for Laser removal of blood vessels_____

The Candela GentleYAG is a device that produces an intense but gentle burst of light that fragments and removes the hair with selective destruction with minimum harm to 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 will feel a cool spray then a hot pulse from the laser.

I have been informed that scarring, blistering, purpura, hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin) are possible risks and complications of this procedure. Usually, if these occur, they are temporary and can resolve in a few days or weeks, but skin discoloration may be permanent.

For the best results, I have been informed that multiple treatments may 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 understand that immediately following the laser treatment; the treated area will appear as a red discoloration (erythema) and have slight edema (swelling), which may last up to two hours or longer. The redness may last up to 2-3 days. The treated area will feel like a sunburn for a few hours after treatment. Possible hyperpigmentation (increased brown color) or hypopigmentation (lighter color pigment) may occur within two weeks of the treatment. If hyperpigmentation occurs, a bleaching cream may be prescribed to reduce the pigmentation. Contact Dr. _____ at _____ with any questions.

Antibiotic ointment or some other soothing ointment or gel, or Aloe Vera gel may be used for a few days after treatment. Improper care of the treated area may increase the chance of scarring or skin textural changes. This has been 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 my identity will not be revealed on these photographs or corresponding text.

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

Signed: _____ Date: _____
(Patient or person legally authorized to consent for patient)

Witness: _____
(To patient's signature)