

Fairfax Skindeep Tattoo Removal Program Laser Treatment Consent Form

The procedure planned is treatment of a tattoo with the Q-Switch Neodymium-YAG, Q-Switch Ruby, or Q-Switch Alexandrite Laser using local, topical, or no anesthesia. The purpose of this procedure is to attempt removal of the tattoo or to make the pattern as unrecognizable as possible by lightening the pigment pattern.

Alternative treatment methods include camouflaging with make-up, tattooing over with a second tattoo, abrasive treatments, acid treatments, treatments with at CO2 laser, cutting out (with tissue expansion or skin grafting if needed), or no treatment.

I understand that the risks of the procedure include possible pain, bleeding, infection, scarring, drug reactions and unforeseen complications. Eye injury is possible but highly unlikely, since complete eye protection is provided throughout laser treatment sessions. There is also risk of patchy residual pigment, persistence of tattoo pattern, change of permanent lightening of skin color, change in skin texture, hair loss or thinning. The risk of scarring (including raised scarring) despite proper treatment, exists in all cases, but can be greatly minimized by proper aftercare and PROMPT treatment by the doctor (within 1-3 weeks of the appearance of the scar). Previous treatment by any method may increase any or all of these risks. _____(initial)

I understand that this procedure fails to remove all pigment in some case, especially with professionally applied tattoos, and may not be effective on certain pigments such as yellow. Laser treatment of white or flesh-colored tattoos can cause dark brown/black color change. Multiple treatments are generally required. I understand my responsibility for properly fulfilling the appropriate aftercare instructions as explained by the doctor, his staff, and/or written or videotaped instructions provided. _____(initial)

I further agree that any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate, unless I notify the doctor in writing that he/she is not to use these photographs. I have received a copy of "Questions and Answers." _____(initial)

I have been asked at this time whether I have any questions about this procedure and do not. I understand the procedure, accept the risks, and request that this procedure be performed on me by Physicians of the Skindeep Program.

PATIENT SIGNATURE

PARENT/GUARDIAN/CARE GIVER OR JUDICIAL SIGNATURE

WITNESS

DATE