DERMALUX CONSENT FORM

Title Miss / Ms / Mrs / Mr / Other _____ **Gender** Female / Male (please circle)

First Name _____ **Surname** _____

Address _____

_____

Postcode _____ **Telephone** _____

Email _____

D.O.B _____ **Occupation** _____

PART ONE: CONSULTATION

There are some circumstances and medical conditions in which Dermalux LED Phototherapy may prove to be unsuitable. Please answer the following questions below. A positive answer may not prevent you from having the Dermalux treatment however further discussion with your practitioner would be required.

Do you currently have or have ever had any of the following: (please circle)

Epilepsy or Seizures	**Yes**	**No**	Skin Cancer	**Yes**	**No**
Porphyria	**Yes**	**No**	Other Cancer	**Yes**	**No**
Lupus Erythematosus	**Yes**	**No**	Eye disease	**Yes**	**No**
Photosensitive Eczema	**Yes**	**No**	Light Induced Headaches	**Yes**	**No**
Hypomelanism (Albinism)	**Yes**	**No**	Are you Pregnant?	**Yes**	**No**

Do you have any other medical conditions including allergies?
If **YES** please specify

_____

_____

Are you taking or applying topically any prescription medications?
Certain medications can induce photosensitivity and may be contra-indicated for the Dermalux treatment.
If **YES** please specify

_____

_____

PART ONE: CONTINUED

(please circle)

Have you started using any new skin care products in the last month?		
Are you currently taking St John's Wort or other herbal remedies?	**Yes**	**No**
Do you smoke?	**Yes**	**No**
Do you have an outdoor lifestyle/activities?	**Yes**	**No**
Do you use sunbeds?	**Yes**	**No**
Have you undergone any cosmetic/aesthetic procedures in the last 7 days?	**Yes**	**No**

If **YES** please specify

_____

_____

ADDITIONAL NOTES

_____

_____

_____

PART TWO: CLIENT CONSENT

I confirm that I have answered all the questions to the best of my knowledge and understand that withholding necessary information about my health and medication may increase my risk of possible side effects.

I will inform my practitioner before every treatment if there has been any change to my circumstances or medication I may be taking.

I understand that the Dermalux systems have not been tested on pregnant women and therefore the risk to the foetus or pregnant woman is unknown.

I understand the benefits and likely clinical outcome of the Dermalux treatment and that multiple treatments are necessary to achieve optimal results.

I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure.

I agree that I have read and understood all the information provided. My questions have been answered satisfactorily and I have made an informed decision to receive the Dermalux treatment.

Client Signature _____

Client Name _____

Practitioner Signature _____

Practitioner Name _____

For (Clinic name) _____ **Date** _____