# Laser & Lipstick LASER TATTOO REMOVAL Consult and Consent Form

Title _____ First Name _____ Surname _____

Address _____

Occupation _____ Email Address _____

Mobile _____ Home Ph _____

Date of Birth _____ Ethnic Background _____

Family Doctor Name and Contact No: _____

Emergency Contact Name and Telephone _____ Relationship _____

How did you find out about our salon? _____

Location of tattoo/s: _____

Is the tattoo: ☐ Professional ☐ Amateur ☐ Traumatic ☐ Surgical ☐ Other: _____

Do you have any current or chronic medical illnesses? ☐ Yes ☐ No Details _____

Are you currently under a doctor's care? ☐ Yes ☐ No Details _____

Have you taken blood thinners or anti-coagulants in last 3 mths? ☐ Yes ☐ No Details _____

Have you taken photosensitising medication in last 3 mths? ☐ Yes ☐ No Details _____

(ie. Anti-depressants, St. John's Wart, Roaccutane etc?)

Do you have (or getting treated for): ☐ Cancer ☐ Heart condition ☐ Poor healing ability ☐ Auto-immune disorder

Have you had (in tattoo area): ☐ Chemical peel ☐ Dermabrasion ☐ Laser ☐ Surgery ☐ Other : _____

Do you have permanent makeup or implants? ☐ Yes ☐ No Details _____

Have you got ANY type of skin tan (fake or natural)? ☐ Yes ☐ No Details _____

Do you smoke? ☐ Yes ☐ No If so, how many per day? _____

Do you have any allergies? ☐ Yes ☐ No If so, please list _____

**Kirby-Desai Scoring**

**Skin Type:**

How would you rate your skin in the area to be treated?

1 ☐ Type I Always burn, never tan. Extremely fair skin/blonde hair/blue/green eyes
2 ☐ Type II Usually burn, tan less than about average. Fair skin, sandy brown to brown hair, green/blue eyes
3 ☐ Type III Sometimes burns, gradually tans about average. Medium skin, brown hair, green/brown eyes
4 ☐ Type IV Sometimes burns, tans Light brown or olive skin, dark brown eyes and hair.
5 ☐ Type V Rarely burns, tans profusely. Dark brown skin, black hair, black eyes
6 ☐ Type VI Deeply pigmented, never burns. Black skin, black hair, black eyes

**Location:**

1 ☐ Head and neck 2 ☐ Upper trunk 3 ☐ Lower trunk 4 ☐ Proximal extremity 5 ☐ Distal extremity

**Colours:**

1 ☐ Black only 2 ☐ Most black, some red 3 ☐ Most black, some red & other 4 ☐ Multiple colours

**Amount of Ink:**

1 ☐ Amateur 2 ☐ Minimal 3 ☐ Moderate 4 ☐ Significant

**Scarring and Tissue Change:**

0 ☐ No scar 2 ☐ Minimal scarring 3 ☐ Moderate scarring 4 ☐ Significant scarring

**Tattoo Layers:**

0 ☐ No 2 ☐ Yes

**Total Points:**

## Test Patch

Test Patch Date _____ Other: _____

Price and Package _____

| Area: | Nm | J/cm$^2$ | Other | Notes |
|---|---|---|---|---|
| Test 1 | | | | |
| Test 2 | | | | |
| Test 3 | | | | |

Client Name: _____ Client Signature: _____ Clinician: _____ Date: _____

## Client Treatment Report

| Date of Treatment | Clinician Name & Signature | Treatment Details | Wavelength | J/cm² | Amount Paid | Clinician Sign |
|---|---|---|---|---|---|---|
| | | | | | | |

# Medical Informed Consent

I consent and authorise Laser and Lipstick to perform laser tattoo removal treatment on me. I understand the following points and have had the opportunity to ask questions during my consultation.

**In relation to my treatment, I have been advised as follows:**

1. Treatment is successful on most clients but my individual results cannot be guaranteed
2. Most clients require 8 to 10 treatments to achieve up to 80% pigmentation reduction, some may require more. Outcome will vary and individual results depend on many factors, thus it is extremely difficult to advise on exact number of treatments required
3. Darker skin type clients will require additional treatments
4. Exposure to UV Rays will compromise my treatment, therefore I will use SPF 30+ sunscreen
5. Home care requirements
6. Treatment process
7. Side effects

Risks associated with laser tattoo removal treatment:

Even though the risk of complication is extremely low, the following can occur: (Please Tick)

☐ Pigment changes (light or dark spots on the skin) lasting 1-6 months. Freckles may temporarily or permanently disappear in treated areas. Other potential risk include crusting, itching, pain, bruising, pimple-like bumps, dry skin, hypopigmentation (lightening of the skin), hyperpigmentation (darkening of the skin), blistering, burns, infection, scabbing, swelling, a very small risk of scarring and a failure to achieve the desired result
☐ Allergic or delayed inflammatory reactions can develop. A test patch is performed to ascertain reaction of the skin
☐ Laser can cause eye injury and protective eyewear must be worn during treatment
☐ I consent to photographs taken to evaluate effectiveness. Photographs revealing my identity will not be used without consent
☐ I understand the laser tattoo removal treatment is uncomfortable and may be quiet painful
☐ I understand lighter coloured inks, such as white, yellow, orange and lighter green, will be ineffective
☐ I am aged 18 years or over (otherwise parent or guardian to sign)
☐ I will advise (salon) of any changes that occur during my treatment that can increase potential risks or reduce efficacy
☐ I also understand that there will be no refund for any performed services

In relation to my initial and all subsequent treatments I advise that: (Please Tick)

☐ I have not had unprotected sun exposure (including tanning beds and fake tan creams) in the last 4 weeks
☐ I have no history of seizures and I have disclosed all known allergies (e.g. Latex, etc)
☐ I am not taking medications causing photosensitivity (prescription/non-prescription) eg. St John's Wort, Anti-coagulants, etc
☐ I do not have a history of keloid & hypertrophic scar formation
☐ I do not have active infections/Immunosuppression
☐ I do not have open lesions in the areas to be treated
☐ I do not have Herpes I or II – in the areas to be treated
☐ I have not used Tretinoin (Retin –A, Renova) within the last 2 weeks.
☐ I have not had Laser Resurfacing within the last 6 months
☐ I have not a Chemical Peel – within the last 4 weeks
☐ I have not used Oral isotretinoin/Accutane – within the last 6 months
☐ I have advised my clinician if I am diabetic
☐ I am not pregnant
☐ I have received the Pre and Post Care Information Sheet. I agree to adhere to all these recommendations
☐ Cancellations: (Enter Policy)

I have read all of the above and had all my questions satisfactorily answered. Note: Do not sign this form until you have read and understood all of the above.

Name in Full _____ Date _____

Signature _____ Clinician (witness) _____