*Wagner Family Eyecare*
*3285 State Route 257*
*PO Box 307*
*Seneca, PA 16346*
*www.wagnerfamilyeyecare.com*

*David A. Wagner, OD*
*Kelly L. Seibert, OD*
*Makayli B. Kepple, OD*
*Phone: (814) 677-6636*
*Fax: (814) 677-9562*

*Please read and initial each statement. Complete, underline or circle individual selection accordingly.*

Initials

- I authorize Doctor _____ to perform IPL™ treatments on me in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia / _____
  Other: _____
- I understand that without eye protection, IPL applied near the eyes may cause severe ocular complications _____
- I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility _____
- I understand the below list of short-term effects and agree to follow matching guidelines:
  - Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring
  - Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams _____
  - Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or anti-inflammatory creams
  - Bruising may rarely occur and may last up to 2 weeks
- I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications _____
- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered _____
- Pre and post-care instructions have been discussed and are completely clear to me _____
- I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required _____
- I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record _____
- I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity _____
- I agree to review the following IPL™ pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge _____



*(1 copy Patient and 1 copy Physician for Medical Record)*
CD-3001953 REV A

*Wagner Family Eyecare*
*3285 State Route 257*
*PO Box 307*
*Seneca, PA 16346*
www.wagnerfamilyeyecare.com

*David A. Wagner, OD*
*Kelly L. Seibert, OD*
*Makayli B. Kepple, OD*
*Phone: (814) 677-6636*
*Fax: (814) 677-9562*

For Dry Eye Disease due to Meibomian Gland Dysfunction:

| | Skin type of the area to be treated: I □ II □ III □ IV □ V □ | | |
|---|---|---|---|
| OptiLight | Ocular surgery or eyelid surgery, within 6 months prior to the first IPL session? | NO | YES |
| | Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL session ? | NO | YES |
| | Uncontrolled eye disorders affecting the ocular surface, for example active allergies ? | NO | YES |
| | Pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area ? | NO | YES |
| | Uncontrolled infections or uncontrolled immunosuppressive Diseases ? | NO | YES |
| | Ocular infections, within 6 months prior to the first IPL session ? | NO | YES |
| | Prior history of cold sores or rashes in the perioral area or in the planned treatment area that could be stimulated by light at a wavelength of 560 nm to 1200 nm, including: Herpes simplex 1 & 2, Systemic Lupus erythematosus, and porphyria ? | NO | YES |
| | Within 3 months prior to the first IPL session, use of photosensitive medication and/or herbs that may cause sensitivity to 560-1200 nm light exposure, including: Isotretinoin, Tetracycline, Doxycycline, and St. John's Wort ? | NO | YES |
| | Radiation therapy to the head or neck, within 12 months prior to the first IPL session ? | NO | YES |
| | Planned radiation therapy, within 8 weeks after the last IPL session | NO | YES |
| | Treatment with chemotherapeutic agent, within 8 weeks prior to the first IPL session ? | NO | YES |
| | Planned chemotherapy, within 8 weeks after the last IPL session ? | NO | YES |
| | History of migraines, seizures or epilepsy ? | NO | YES |
| | Tattoos in the planned treatment area ? | NO | YES |
| | Exposure to sun or artificial tanning during 3-4 weeks prior to Treatment ? | NO | YES |
| | Any remaining suntan, sunburn or artificial tanning products ? | NO | YES |

Wagner Family Eyecare
3285 State Route 257
PO Box 307
Seneca, PA 16346
www.wagnerfamilyeyecare.com

David A. Wagner, OD
Kelly L. Seibert, OD
Makayli B. Kepple, OD
Phone: (814) 677-6636
Fax: (814) 677-9562

For all other conditions (relevant for an upgraded configuration of the OptiLight device):

| | | | |
|---|---|---|---|
| | Skin type of the area to be treated: I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐ | | |
| | Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan | NO | YES |
| | Use of self–tanners or tan enhancer caps within the past 3-4 weeks pre-op plan | NO | YES |
| | Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc...) or aromatherapy (essential oils) | NO | YES: ..... |
| | Diseases which may be stimulated by light at 400 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria | NO | YES: ..... |
| | Pregnant or possibility of pregnancy, postpartum or nursing | NO | YES |
| | Inflammatory skin conditions (dermatitis, etc...) | NO | YES: ..... |
| | Presence or history of active cold sores or herpes simplex virus | NO | YES |
| HR | HIV | NO | YES |
| PL | Active cancer (currently on chemotherapy or radiation) | NO | YES |
| SR | Previous skin cancer? | NO | YES |
| VL | Medical history of keloids | NO | YES |
| | Intake of isotretinoin within the past year | NO | YES |
| | Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis) | NO | YES: ..... |
| | Any known allergy? | NO | YES: ..... |
| | Any tattoo and/or pigmented lesion on requested treatment area that should be protected? | NO | YES |
| | List of additional current medication taken | | |
| HR | Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?) | NO | YES: ..... |
| | Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc...) | NO | YES: what/when? ..... |
| PL SR VL | Any observed modification (colour, size, texture and border) on the lesion to be treated? | NO | YES: ..... |
| | Any hair on requested treatment area that should not be removed? | NO | YES |
| | Age of lesion onset? | | |
| PL SR | Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...) | NO | YES: what/when? ..... |
| SR | Intake of aspirin or anti-coagulants? | NO | YES: ..... |
| VL | Easy bruising? | NO | YES |

*Wagner Family Eyecare*
*3285 State Route 257*
*PO Box 307*
*Seneca, PA 16346*
*www.wagnerfamilyeyecare.com*

*David A. Wagner, OD*
*Kelly L. Seibert, OD*
*Makayli B. Kepple, OD*
*Phone: (814) 677-6636*
*Fax: (814) 677-9562*

My signature certifies that I duly read and understood the content of this informed consent form, and that I gave the accurate information as to my health condition. I hereby freely consent to OptiLight IPL treatments

| Name of patient (please print) | Signature of patient | Date |
|---|---|---|
| Name of witness (please print) | Signature of witness | Date |

*Wagner Family Eyecare*
*3285 State Route 257*
*PO Box 307*
*Seneca, PA 16346*
*www.wagnerfamilyeyecare.com*

*David A. Wagner, OD*
*Kelly L. Seibert, OD*
*Makayli B. Kepple, OD*
*Phone: (814) 677-6636*
*Fax: (814) 677-9562*

*Please read and initial each statement. Complete, underline or circle individual selection accordingly.*

**Patient Name:**_____
**Patient Signature:**_____
**Date:**_____ **Intials:**

☐ I authorize Wagner Family Eyecare to perform IPL™ treatments on me. _____

in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia / Other:

_____

☐ I understand that without eye protection, IPL applied near the eyes may cause severe ocular complications. _____

☐ I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility. _____

☐ I understand the below list of short-term effects and agree to follow matching guidelines:

- Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring.
- Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams. _____

Wagner Family Eyecare
3285 State Route 257
Seneca PA 16346
814 677-6636

**Patient Name**_____**Date:**_____

***Please read and initial each statement. Complete, underline or circle individual selection accordingly.***

- Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or anti-inflammatory creams.
- Bruising may rarely occur and may last up to 2 weeks.

_____

☐ I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications.

_____

☐ The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered.

☐ Pre and post-care instructions have been discussed and are completely clear to me. _____

☐ I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required. _____

☐ I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record. _____

☐ I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity. _____

☐ I agree to review the following IPL™ pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge. _____

# Skin typing assessment quiz



One of the most important factors in deciding which Laser/IPL™ (and settings) to use is the patient skin type. Skin typing is determined by genetics, reaction of the skin to sun exposure and tanning habits.
The following skin type quiz[1] is intended ***as a sample only*** to provide additional help in the evaluation of an individual skin type. *Skin typing of the area to be treated* is to be assessed. Lumenis takes no liability on that document and its content is not intended to be a substitute for professional medical diagnosis.

| ***Genetic predisposition*** | | | | | | **Report Score ↓** |
|---|---|---|---|---|---|---|
| **Score →** | **0** | **1** | **2** | **3** | **4** | |
| What is the colour of your eyes? | Light blue, grey, green | Blue, grey or green | Blue | Dark brown | Brownish black | ..... |
| What is the natural colour of your hair? | Sandy red | Blond | Chestnut, dark blond | Dark brown | Black | ..... |
| What is the colour of your skin (non-exposed areas)? | Reddish | Very pale | Pale with beige tint | Light brown | Dark brown | ..... |
| Do you have freckles on non-exposed areas? | Many | Several | Few | Incidental | None | ..... |
| | | | | | ***Total score for genetic predisposition:*** | ..... |

| ***Reaction to sun exposure*** | | | | | | **Report Score ↓** |
|---|---|---|---|---|---|---|
| **Score →** | **0** | **1** | **2** | **3** | **4** | |
| What happens when you stay in the sun too long? | Painful redness, blistering, peeling | Blistering followed by peeling | Burns sometimes followed by peeling | Rare burns | Never had burns | ..... |
| To what degree do you turn brown? | Hardly or not at all | Light colour tan | Reasonable tan | Tan very easy | Turn dark brown quickly | ..... |
| Do you turn brown within several hours after sun exposure? | Never | Seldom | Sometimes | Often | Always | ..... |
| How does your face react to the sun? | Very sensitive | Sensitive | Normal | Very resistant | Never had a problem | ..... |
| | | | | | ***Total score for reaction to sun exposure:*** | ..... |

| ***Tanning habits*** | | | | | | **Report Score ↓** |
|---|---|---|---|---|---|---|
| **Score →** | **0** | **1** | **2** | **3** | **4** | |
| When did you last expose your body to sun (or artificial sunlamp/self-tanning cream)? | More than 3 months ago | 2-3 months ago | 1-2 months ago | Less than a month ago | Less than 2 weeks ago | ..... |
| Did you expose the area to be treated to the sun? | Never | Hardly ever | Sometimes | Often | Always | ..... |
| | | | | | ***Total score for tanning habits:*** | ..... |

***Add up the total scores for each of the three sections for your Skin Type Score:*** .....

[1] Quiz adapted from the Radiation protection (tanning units) amendment regulation by the Australian Government Health Directorate and the American Skin Cancer Foundation