Facial Plastic Surgery Center

AURORA SKIN TREATMENT CONSULTATION

Personal Information			
Name		Home Phone	
Address		Work Phone	
City		Province	
Postal Code		Date of Birth	
Referred by		Sex	Male/ Female

Medical History			
Bleeding disorder, bruise easily		Endocrine / hormone issues	
Pigmentation disorder		Pacemaker / defibrillator	
History of cold sores		Accutane within 6 months	
History of keloid scarring		History of skin cancer	
Dermatological conditions		Photoallergic	
List any medications taken			
Medical conditions			
List any allergies			

Contraindications:

- Tanned skin (active or passive)
- Pacemaker or internal defibrillator
- Accutane taken in last 6 months
- History of keloid scarring
- Any abnormal or undiagnosed pigmentation should be avoided
- Atypical moles or malignancy
- Non-intact skin (i.e. sores, psoriasis, eczema, infection, rash) should be avoided
- Recent chemical or mechanical peeling in treatment area (within 2 weeks)
- Laser resurfacing in treatment area within 3 months
- Any medical condition involving impairment of skin structure, esp. healing patterns
- Poorly controlled diabetes
- Pregnancy

Precautions: (treat with caution if patient has any of following risk factors)

- Medications that may cause photosensitivity to light 580-980 nm
- Healing impaired
- History of skin cancer in treatment area, family history of melanoma
- Nickel allergy. Test patients that have known nickel sensitivity, the electrodes are nickel-plated.

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Skin Type Assessment				
Fitzpatrick Skin type	**I II III IV**		Ethnicity	
Tan present	Yes / No	Sunscreen daily?		Always/ Sometimes/Never
Skin care regimen				
Vascular lesions				
Pigmented lesions				
Textural irregularities				

**Improvements achieved by each treatment may not be evident until weeks later.*

Hair Assessment			
Location (circle)	Upper lip Chin Sideburns Forehead Cheeks Other_____		
Hair density	Sparse/ Medium/ Dense	Hair thickness	Fine/ Medium/ Coarse
Hair color		Other	

**counsel patient that hairs in treatment area may also be reduced or miniaturized as result of skin treatment. Base line photos/photo documentation is recommended.*

Possible Side Effects:

- Temporary mild discomfort from treatment, may feel warmth or tingling
- Temporary swelling, redness in treatment area
- Temporary 'darkening' of pigmented lesions before becoming lighter
- Superficial scabbing, crusting or blister
- Transient or permanent dyschromia from epidermal injury

Treatment Schedule:

- Treatment done at monthly intervals. May retreat as soon as 3 weeks for some patients.
- 5 treatments in treatment series. Some lesions may fade significantly after a single treatment. Collagen stimulation is a delayed and cumulative response, 5 treatments recommended for this indication.
- Maintenance treatments may be done to help maintain results, or to treat new lesions.

**Clinical guidelines for skin treatment currently exist only for skin types I-IV. Treatment for darker skin types is under investigation, and should only be attempted by experienced practitioners.*

8316 Arlington Blvd. Suite 320, Fairfax, VA 22031 ***Ph: 703-573-3612***

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Informed Consent Aurora Skin Treatment

Patient name _____

Treatment sites _____

I duly authorize _____ to perform the Aurora Skin Treatment procedure and any other measures which in their opinion may be necessary.

I understand that the Aurora is a device used for skin treatment and that clinical results may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, mild blistering or scabbing, temporary bruising and temporary discoloration of the skin; as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Aurora Skin Treatment system involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I do not have a history of keloid scarring, have not had deep chemical or mechanical peeling within last 2 weeks preceding treatment, and do not have poorly controlled diabetes.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature_____ Date_____

Witness_____

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Aurora *DS / SR* Treatment Record

CLIENT NAME**:**

SKIN TYPE**: I II III IV V VI**

Date	Tx area	Optical fluence	RF fluence	Pulse type	ISL %	Notes
				S / L		
				S / L		
				S / L		
				S / L		
				S / L		
				S / L		
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				S / L		
				S / L		

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