CHERRY CREEK EYE PHYSICIANS AND SURGEONS, PC

Stuart A. Lewis, MD & Tammy Gray, OD, Rachel Lewis, OD

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

Initials

- I authorize Cherry Creek Eye Physicians & Surgeons to perform IPL treatments on me in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangiomia / 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 that 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 sensitivity of the area to be treated. These phenomena may be reduced with the application of cooling and/or anti-inflammatory creams.
  - Bruising may rarely occur and my 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. _____

- 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 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 to 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. _____

For Dry Eye Disease due to Meibomian Gland Dysfunction:

Skin type of the area to be treated:	I ☐	II ☐	III ☐	IV ☐	V ☐

Ocular surgery or eyelid surgery, within 6 months prior to the first IPL session?	Yes	No
Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL session?	Yes	No
Uncontrolled eye disorders affecting the ocular surface, for example active allergies?	Yes	No
Pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area?	Yes	No
Uncontrolled infections or uncontrolled immunosuppressive diseases?	Yes	No
Ocular infections, within 6 months prior to the first IPL session?	Yes	No
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?	Yes	No
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?	Yes	No
Radiation therapy to the head or neck, within 12 months prior to the first IPL session?	Yes	No
Planned radiation therapy, within 8 weeks after the last IPL session?	Yes	No
Treatment with chemotherapeutic agent, within 8 weeks prior to the first IPL session?	Yes	No
Planned chemotherapy, within 8 weeks after the last IPL session?	Yes	No
History of migraines, seizures or epilepsy?	Yes	No
Tattoos in the planned treatment area?	Yes	No
Exposure to sun or artificial tanning during 3-4 weeks prior to treatment?	Yes	No
Any remaining suntan, sunburn or artificial tanning products?	Yes	No

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

Name of patient (please print) Signature of patient Date

Name of witness (please print) Signature of witness Date

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Skin Typing Assessment Quiz

One of the most important factors in deciding which Laser/IPL (and setting) 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 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 color of your eyes?	Light blue, grey, green	Blue, grey, or green	Blue	Dark Brown	Brownish Black	
What is the natural color of your hair?	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black	
What is the color 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 color 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 often 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: _____

Skin Typing Assessment Quiz

Skin type score ⬇	Skin type	Features
0-7	I	Caucasian / freckles Always burns and never tans
8-16	II	Caucasian / freckles Burns easily and tans minimally (white skin)
17-25	III	Darker Caucasian Burns moderately and tans gradually (light brown skin)
25-30	IV	Mediterranean, Asian, Hispanic Burns minimally and always tans well (moderate brown skin)
Over 30	V	Middle Eastern, Latin, light-skinned black, Indian Rarely burns and tans profusely (dark brown skin)
	VI	Never burn (deeply pigmented dark brown to black skin)

Report total skin type score: _____ **Quiz skin type:** _____ **Diagnosed skin type:**_____

Has a consent form been signed? Yes / No

Has an additional pre-treatment compliance checklist been completed? Yes / No

Assessment conducted by (print name): _____ Date: _____

Name of Patient: _____

Patient Signature: _____
(I attest hereby that I have answered the above to the best of my knowledge)

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SPEED Questionnaire

Name: _____ **Date:** _____/_____/_____

(Last) (First)__

DOB: _____/_____/_____ **Sex:** M F

Report the type of **SYMPTOMS** you experience and when they occur.

SYMPTOMS	AT THIS VISIT		WITHIN PAST 72 HRS		WITHIN PAST 3 MONTHS	
	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

Report the **FREQUENCY** of the above-checked symptoms as **Never (0), Sometimes (1), Often (2) or Constant (3)** using the numbering system below:

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of your Symptoms using the rating list below:

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No problem
1 = Tolerable (not perfect but not uncomfortable)
2 = Uncomfortable (irritating but does not interfere with my day to day)
3 = Bothersome (irritating and interferes with my day)
4 = Intolerable (unable to perform my daily tasks)

Do you use drops and/or ointment? **Y or N** If yes, what drops do you use? _____