Pixel Laser

PIXEL LASER

Status: active Form type: default Company: Acme Inc

Pixel laser is a fractional ablative laser treatment used to resurface the skin and improve its texture, tone, and appearance. It targets microscopic zones of skin while leaving surrounding areas intact, promoting faster healing. It is commonly used to treat acne scars, fine lines, wrinkles, sun damage, and enlarged pores. Risks and Side Effects: Possible side effects include redness, swelling, tenderness, flaking or peeling, itching, temporary darkening or lightening of the skin, infection, scarring, and persistent erythema. There may be a risk of hyperpigmentation, especially in individuals with darker skin tones. A patch test may be advised. Multiple sessions may be required to achieve desired results. Contraindications: Pixel laser treatment may not be suitable for individuals who are pregnant, breastfeeding, have active skin infections, are prone to keloid scarring, have used isotretinoin in the past 6 months, or have certain medical conditions or medications that increase photosensitivity. Aftercare: Proper post-treatment care is essential. This includes avoiding sun exposure, applying recommended healing ointments or moisturisers, using gentle cleansers, and avoiding picking or scratching the treated area. Sunblock should be used diligently. Healing typically takes a few days to a week, depending on the intensity of the treatment. Informed Consent and Photography I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: the aims/motivations for having the procedure and the desired outcome the risks inherent in the procedure the risks inherent in refusing the procedure the risks specific to me the expected benefits of the treatment the potential disadvantages of the treatment alternative procedures and their pros and cons – including the option of no treatment at all any uncertainties about and the likelihood of success of the procedure any follow-up treatment that may be required Clinical Photographs and Videos: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records. I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.

◯ Yes ◯ No