

**Spa Catalina**  
**8333 N. Congress Ave.**  
**Kansas City, Missouri 64152**  
**816 505 3772**  
**www.spacatalina.com**

**Intense Pulsed Light (IPL) Consent Form**

The Palomar Medilux is an intense pulsed light (IPL) device used for the treatment of benign pigmented and vascular skin lesions. IPL treatments are a series of approximately 4-5 treatments performed at approximately 3-4-week intervals. Actual results vary from patient to patient. The IPL treatment is a cosmetic procedure and insurance is not accepted.

The procedure is contraindicated in the following situations: pregnancy, the use of medications that cause photosensitivity (sensitivity to sunlight/light), the use of anticoagulants (blood thinners), a history of bleeding disorders, sun exposure (tanning) 3 weeks prior to treatment, or planned sun exposure within 1 week after any treatment. Diseases that increase sensitivity to sunlight/light (Lupus/SLE) or very dark skin types also should not undergo IPL treatments.

I understand that there are possible risks to these treatments. These risks include rare side effects such as scarring and permanent skin discoloration as well as short-term effects such as redness, burning, bruising and temporary skin discoloration. These side effects have all been fully explained to me and I accept the risks of the IPL treatment series.

I understand that IPL treatments may affect hair growth. For this reason we do not treat over men's bearded areas unless expressly discussed in consultation.

To achieve optimal results from the IPL treatment series, we strongly encourage maintenance treatments. Usually this consists of 1 treatment every 4-6 months.

**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.**

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_  
**(Please Print)**

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**IPL Client Treatment History**

1. Location of concern (e.g. areas of face, neck) to be treated:

\_\_\_\_\_

2. Have you ever been treated for this/these problem(s)? Yes \_\_\_\_\_ No \_\_\_\_\_

When? \_\_\_\_\_

What method of treatment? \_\_\_\_\_

3. Do you have any medication allergies? (Please list) \_\_\_\_\_

Any skin related allergies? (Please list) \_\_\_\_\_

4. Do you have a history of HSV (cold sores, fever blisters)? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Some medication may increase sun/light sensitivity and/or cause bruising. These include: *Aspirin, Ibuprofen, Anticancer drugs, Antihistamines, Antibiotics, Antidepressants, Diuretics, Antihypertensives, Anti-inflammatory, and Antiparasitics.*

Please list all current medications, including oral, topical, over-the-counter, and herbal supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate if you are currently using any of these medications/products:

Retin-A? Yes \_\_\_\_\_ No \_\_\_\_\_ if Yes, date of last use: \_\_\_\_\_

Glycolic Acid? Yes \_\_\_\_\_ No \_\_\_\_\_ if Yes, date of last use: \_\_\_\_\_

Topical Cortisone? Yes \_\_\_\_\_ No \_\_\_\_\_ if Yes, date of last use: \_\_\_\_\_

6. (For Female Patients) Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

7. Have you taken Accutane within the last six months? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, when was your last dose? \_\_\_\_\_

8. Have you had any alcohol in the last 48 hours? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Have you had recent sun exposure in the area to be treated?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_
10. Do you use self-tanners (“fake tan”)? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, then when was the last application? \_\_\_\_\_
11. Do you use a sunscreen? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, how often do you apply? \_\_\_\_\_ What is the SPF? \_\_\_\_\_
12. Have you ever been diagnosed with a disorder associated with photosensitivity (For example, systemic lupus erythematosus)?  
Yes \_\_\_\_\_ No \_\_\_\_\_
13. Do you have any cosmetic tattoos/permanent makeup on your face?  
Yes \_\_\_\_\_ No \_\_\_\_\_ if so, where? \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
**(Please Print)**



