



Laser Tattoo Removal Consent Form

I consent and authorise _____ to perform laser tattoo removal treatment on me. I understand the following points and have had the opportunity to ask questions during my consultation.

In relation to my treatment, I have been advised as follows:

1. Treatment is successful on most clients but my individual results cannot be guaranteed
2. Most clients require 8 to 10 treatments to achieve up to 80% pigmentation reduction, some may require more. Outcome will vary and individual results depend on many factors, thus it is extremely difficult to advise on exact number of treatments required
3. Darker skin type clients will require additional treatments
4. Exposure to UV Rays will compromise my treatment, therefore I will use SPF 30+ sunscreen
5. Home care requirements
6. Treatment process
7. Side effects

Risks associated with Tattoo Removal treatment:

Even though the risk of complication is extremely low, the following can occur: (Please Tick)

- Pigment changes (light or dark spots on the skin) lasting 1-6 months. Freckles may temporarily or permanently disappear in treated areas. Other potential risk include crusting, itching, pain, bruising, pimple-like bumps, dry skin, hypopigmentation (lightening of the skin), hyperpigmentation (darkening of the skin), blistering, burns, infection, scabbing, swelling, a very small risk of scarring and a failure to achieve the desired result
- Allergic or delayed inflammatory reactions can develop. A test patch is performed to ascertain reaction of the skin
- Laser can cause eye injury and protective eyewear must be worn during treatment
- I consent to photographs taken to evaluate effectiveness. Photographs revealing my identity will not be used without consent
- I understand the laser tattoo removal treatment is uncomfortable and may be quite painful
- I understand lighter coloured inks, such as white, yellow, orange and lighter blue/green, will be ineffective
- I am aged 18 years or over (otherwise parent or guardian to sign)
- I will advise my clinician of any changes that occur during my treatment that can increase potential risks or reduce efficacy
- I also understand that there will be no refund for any performed services

In relation to my initial and all subsequent treatments I advise that: (Please Tick)

- I have not had unprotected sun exposure (including tanning beds and fake tan creams) in the last 4 weeks
- I have no history of seizures
- I have disclosed all known allergies (e.g. Latex, etc)
- I am not taking medications causing photosensitivity (prescription/non-prescription) eg. St John's Wort, Anti-coagulants, etc
- I do not have a history of keloid & hypertrophic scar formation
- I do not have active infections/Immunosuppression
- I do not have open lesions in the areas to be treated
- I do not have Herpes I or II – in the areas to be treated
- I have not used Tretinoin (Retin –A, Renova) within the last 2 weeks.
- I have not had Laser Resurfacing in the treatment area within the last 6 months
- I have not a Chemical Peel in the treatment area within the last 2 weeks
- I have not used Oral isotretinoin/Accutane – within the last 6 months
- I have advised my clinician if I am diabetic

- I am not currently unwell (e.g. cold/flu)
- I am not pregnant or breastfeeding
- I have received the Pre and Post Care Information Sheet. I agree to adhere to all these recommendations
- I understand the cancellation and rescheduling policy

I have read all of the above and had all my questions satisfactorily answered. Note: Do not sign this form until you have read and understood all of the above.

Name in Full _____ Date _____

Signature _____ Clinician (witness) _____