

PATIENT INFORMATION	
Patient Name	Date
Date of Birth	Age
Email Address	
Address	
City	County
Postal Code	Phone
EMERGENCY CONTACT	
Name	Phone

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

	Initials
I consent to having IPL treatments on me to improve dry eye disease (DED) and/or address my skin concerns.	
I understand with any IPL procedure there can be some potential complications and side effects including a) chance of developing hypo and/or hyperpigmentation; b) purpura, blistering, crusting, and scarring; c) freckles and brown spots may lighten and disappear; d) perifollicular edema and erythema (redness and swelling); e) feel itchiness in the treated area.	
I understand with any IPL procedure there can be short-term effects including: A. A sensation like a rubber band snap: This sensation may vary according to the condition of your skin and degree of sensitivity, but this feeling won't last long. B. Mild sunburn sensation: It can usually appear up to an hour after treatment and will disappear with the use of cooling and soothing creams. C. Redness and swelling of the skin: Erythema (redness) and edema (swelling) may appear and should disappear within 5-7 days after IPL treatment. The severity and duration depend on the energy (Fluence) used in the treatment and the sensitivity of the area to be treated. This inflammation and redness generally disappear with the use of cooling and/or anti-inflammatory creams. D. Bruising: This may rarely occur and is caused by small injuries to blood vessels that are just below the surface of the skin. In general, this can happen if you have taken aspirin or aspirin-containing products or blood-thinning medications. It should disappear within 7-14 days after IPL treatment.	

I understand that I cannot expose the area to be treated 3 to 4 weeks before treatment to the sun or tanning beds, high pressure UV treatment with the last 10 day and will avoid self-tanner 2 weeks before treatment. I agree to protect the treated area with sunscreen for 4 weeks	
I understand that to have the best result possible I agree to the treatment intervals as the clinic designs for me. I agree to follow post-care instructions.	
I have had the process thoroughly explained to me. I understand the potential benefits and complications and willingly agree to undergo IPL treatments.	
I agree to review the following contraindications pre-treatment compliance checklist along with my doctor and bring accurate and updated data, to the best of my knowledge	

MEDICAL HISTORY

Which skin type best describes you? Please circle: I Always burns, never tans II Always burns, sometimes tans III Sometimes burns, always tans IV Rarely burns, always tans V Brown, moderately pigmented skin VI Black Skin	
Are you currently under the care of a physician	Yes ☐ No ☐
Natural or artificial sun exposure 3-4 weeks before treatment. Facial sunburn which has healed within the last month	Yes ☐ No ☐
Use of self-tanners or tan enhancer cap 2 weeks before treatment.	Yes ☐ No ☐
Photosensitising; herbal preparations (St John's Wort, Ginkgo Biloba, etc...) or aromatherapy (essential oils) any food supplements which promote tanning, medical treatment under a doctor	Yes ☐ No ☐
Use of tetracyclines, sulfonamides, NSAIDs, sulfonylureas, antimalarial drugs, diuretics, antidepressants tricyclics, anti-anxiety drugs or any other medication that cause photosensitivity	Yes ☐ No ☐
Use or retinoids (tretinoin) or topical AHA acids (glycolic and lactic acid for chemical peeling) 2 to 4 weeks before IPL.	Yes ☐ No ☐
Previous skin procedures on requested treatment area (Botox, fillers) 2-3 days before IPL	Yes ☐ No ☐
Microdermabrasion, chemical peels, retinol, photo sensitising medical treatment less of 4 weeks before IPL	Yes ☐ No ☐

Systemic diseases such Lupus Erythematosus or Porphyria	Yes ☐ No ☐
History of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irradiation	Yes ☐ No ☐
Pregnant or possibility of pregnancy, postpartum or nursing	Yes ☐ No ☐
Inflammatory skin conditions (dermatitis, etc...) or infections in the area in which is to receive flash treatment	Yes ☐ No ☐
Melasma, is a skin condition characterised by brown or blue-gray patches or freckle-like spots. It's often called the "mask of pregnancy."	Yes ☐ No ☐
History of an autoimmune disease, in which the blood vessels are constricted, or narrowed resulting in mottled discoloration on large areas of the leg or arms	Yes ☐ No ☐
History of vasculitis such as Polyarteritis nodosa, Hypersensitivity vasculitis (Allergic), Cryoglobulinemia, Bechet's disease.	Yes ☐ No ☐
Presence or history of active cold sores or herpes simplex virus	Yes ☐ No ☐
HIV	Yes ☐ No ☐
Active cancer (currently on chemotherapy or radiation)	Yes ☐ No ☐
Previous skin cancer	Yes ☐ No ☐
Medical history of keloids	Yes ☐ No ☐
Intake of isotretinoin (Accutane) within the past 6 months	Yes ☐ No ☐
Medical history of vitiligo or psoriasis	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐
Hepatitis	Yes ☐ No ☐
Seizure disorder e.g. epilepsy	Yes ☐ No ☐
Skin disease/lesions/facial dermatological pathologies	Yes ☐ No ☐

Hormonal or endocrine disorders (Thyroid imbalance and uncontrolled diabetes?)	Yes ☐ No ☐
Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma?	Yes ☐ No ☐
Blood clotting abnormalities	Yes ☐ No ☐
Any tattoo and/or pigmented lesion on the requested treatment area that should be protected?	Yes ☐ No ☐
Use of aspirin or anti-coagulants?	Yes ☐ No ☐
Easy bruising	Yes ☐ No ☐
List of ALL the medication you are currently taking and medical devices fitted (e.g. pacemaker, diabetic pump):	
Do you have any other health problems or medical conditions not listed above? If so, please describe it below.	
Do you have any history of allergies, including sunlight? If so, please describe it below.	

I am aware of the fees for this service. £XXXXX pay as you go or £XXXXX pre-paid bundle. Fee for Lipi flow is £XXXXX. IPL/Lipi flow bundle £XXXXX.

I have read this consent form. I have had the opportunity to discuss the IPL treatment with my doctor and / or his/her staff. I have had my questions answered in language I understand. The risks and benefits have been explained to me, and I am aware that it is my responsibility to inform the technician, doctor, or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Also, I believe that I have not been unduly influenced by any member of the clinical staff to take this treatment by any statement or implied statements. I understand that I will be given a copy of this consent form after signing it.

Name of patient (please print) _____ **Signature of patient** _____

Date _____

Name of witness (please print) _____ **Signature of witness** _____

Date _____

UK GDPR & Privacy Notice

Tunnell Vision is committed to protecting your privacy and handling your personal information responsibly. The personal and special category health information collected within this form will be used for the purposes of assessing your suitability for treatment, providing clinical care, maintaining accurate medical records, communicating with you regarding your treatment, and meeting our legal and regulatory obligations.

Your information is processed in accordance with the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018, and professional obligations imposed by the General Optical Council (GOC). We will only collect information that is relevant to your care and will retain your records securely for the period required by law and professional guidance.

Your information will not be shared with third parties unless:

- You have given your consent;
- It is necessary for your ongoing healthcare;
- We are required to do so by law or regulatory authorities; or
- It is necessary to protect your vital interests or those of another individual.

You have the right to request access to your personal information, request correction of inaccurate information, request restriction of processing in certain circumstances, and lodge a complaint with the Information Commissioner's Office (ICO) if you believe your information has been handled improperly.

By signing this form, you acknowledge that Tunnell Vision has explained how your personal information will be collected, stored and processed, and you consent to the use of your information for the purposes described above.

☐ I have read and understood the Tunnell Vision Privacy Notice and consent to the processing of my personal and health information for the purposes of my care and treatment.

Name of patient (please print) _____ Signature of patient _____

Date _____