**THEODORE L. GERSTLE, M.D.**
1760 Nicholasville Rd Bldg C Suite 402
Lexington, Kentucky 40503
(859) 279-2111

Lexington Plastic Surgery

## CARBON DIOXIDE LASER RESURFACING / CHEMICAL PEEL

## REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT: _____ DATE: _____/_____/_____

I understand that the above named procedure has been explained and is to be performed on me. The following has been explained to me in general terms and I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is facial rhytides (wrinkles), skin laxity, or a certain skin condition which may respond favorably to laser resurfacing or chemical peel.

2. The **NATURE OF THE PROCEDURE** is to use the laser or a topically applied chemical agent to remove the outer layers of the skin. The $CO_2$ laser emits an intense beam of light that heats and vaporizes skin tissues instantaneously. It is done so precisely that surrounding tissue is hardly affected. Both chemical peels and $CO_2$ laser resurfacing initially cause the skin to become swollen, red, raw, and painful. The pain usually lasts for several days after laser treatment. After a few days, the skin is covered with a hard crust that will gradually fall off over the ensuing several weeks. In some patients, the redness will persist for a longer period. The majority of chemical peels have a significantly shorter healing phase than with laser treatment. Generally, $CO_2$ laser resurfacing or chemical peel generates an improvement of the skin. However, a perfect result is not often a realistic expectation. LINES OF EXPRESSION WILL RETURN.

3. The **PURPOSE OF THIS PROCEDURE** is to attempt to improve the appearance of wrinkles or other skin conditions.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. Sometimes makeup may help somewhat if skillfully applied. Other alternative include dermabrasion, and other surgery.

5. **IF I CHOOSE NOT TO HAVE THE ABOVE NAMED PROCEDURE, MY PROGNOSIS (future medical condition)** is not completely predictable and the medical condition may get better, may get worse, or may stay the same. However, failure to have the procedure may result in possible progression of the medical condition and/or the possible need for more extensive surgery if the medical condition progresses and remains undiagnosed or untreated. Diet, exercise, pregnancy, aging, sun exposure, and health problems may all contribute to future changes in my medical condition.

6. **MATERIAL RISKS OF THIS PROCEDURE:** As a result of this procedure being performed, there may be material risks of: INFECTION, ALLERGIC REACTION, TOXIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.

7. In addition to these material risks, there may be **OTHER POSSIBLE RISKS** involved in this procedure including but not limited to:

    1. Increased chance of developing cold sores or generalized reactivation of herpes viral infection.

    2. Scars may occur and may be PERMANENT and VISIBLE.

    3. Delayed wound healing may occur which will yield prolonged swelling, weeping, and crusting over the treated area. Once the surface is healed, it is pink and may become sensitive to the sun for another two to six weeks or longer.

    4. The treated area may heal with increased or decreased pigmentation. This occurs most often in darker pigmented skin and following exposure of the area to the sun. It is recommended that you protect yourself from any sun exposure from three to six months following treatment. Hyperpigmentation usually fades in three to six months. However, pigment changes may be permanent.

    5. There is also a risk of harmful eye exposure to laser surgery. Safeguards have been provided. It is important that you keep your eyes closed and have protective eyewear at all times during the laser treatment.

8. There may be a need for immediate or other additional surgery to treat the above complications, which could include hospitalization, time off work and additional expense to me.

9. I understand that my expectations should be realistic and I should consider not undergoing the surgery if my expectations are greater than the reality of this treatment. Psychological problems may occur due to unrealistic expectations of the procedure or difficulties in accepting changes in my appearance.

10. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE.

11. I consent to the taking of pictures during the course of my treatment for the purpose of helping to plan and assess the proposed therapy. No photographs will be shown to patients or physicians without my permission. If any portion of the surgery is billed to insurance (this does not include surgery for cosmetic reasons), I understand my insurance carrier may require photographs to process my claim.

12. On occasion, surgical revisions may be indicated following the original surgery. If planned or performed within one (1) year after the original surgery, there will be no charge by the surgeon. However, a fee will be charged by the facility for use of the operating room, and by the anesthesiologist if indicated. There may also be an additional charge for the rental of the $CO_2$ laser.

13. I voluntarily consent to allow Dr. Gerstle and all medial personnel under his direct supervision and control, and all other personnel who may otherwise be involved in performing such procedures to perform the procedure(s) described or otherwise referred to herein.

14. BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT MY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY.

Signature of person giving consent:_____ Date: _____

Relationship to patient if not the patient:_____

Witness:_____ Date: _____