

## CARBON DIOXIDE (CO<sub>2</sub>) LASER SURGERY SKIN RESURFACING

The term "LASER" stands for Light Amplification by the Stimulated Emission of Radiation. A laser is a special light beam that can be precisely focused and is used to treat tissues by heating the targeted cells until they "burst." Laser treatment can: 1) destroy diseased tissues (such as tumors), 2) seal small blood vessels (coagulation) to reduce blood loss, 3) reduce scarring normally associated with non-laser surgeries, and 4) be used for cosmetic purposes including removal of tattoos or birthmarks and skin resurfacing.

Patient's  
Initials

\_\_\_\_\_ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

\_\_\_\_\_ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

\_\_\_\_\_ I understand and accept that the most likely material risks and complications of carbon dioxide laser surgery skin resurfacing have been discussed with me and may include but are not limited to:

- *dissatisfaction with results*
- *eye exposure*
- *infection*
- *pain and discomfort*
- *recurrence of lesions*
- *scarring*
- *skin color change*
- *swelling*

\_\_\_\_\_ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

\_\_\_\_\_ I have informed the doctor of all my known allergies.

\_\_\_\_\_ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

\_\_\_\_\_ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

\_\_\_\_\_ I am aware and accept that no guarantees about the results of the procedure have been made.

\_\_\_\_\_ I have been advised of the probable consequences of declining recommended or alternative therapies.

\_\_\_\_\_ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

\_\_\_\_\_ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct \_\_\_\_\_, M.D., and assistants of his/her choice to perform laser treatment of \_\_\_\_\_ at \_\_\_\_\_.  
(patient name) (name of facility)

*Continued*

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

\_\_\_\_\_  
Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient or Legal Representative Name

\_\_\_\_\_  
Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

\_\_\_\_\_  
Physician Signature/Date/Time

\_\_\_\_\_  
initial

copy given to patient

\_\_\_\_\_  
initial

original placed in chart

SAMPLE