

## VASCULAR LESION LASER CONSENT

The Candela Vascular Lesion Laser (VBeam™) is used to treat abnormal blood vessels that are seen in conditions such as port wine stain birthmarks, strawberry hemangiomas, and telangiectasia (broken capillaries of spider veins).

The Vascular Lesion Laser is a device that produces an intense but gentle burst of light that is absorbed by the abnormal blood vessels without causing damage to surrounding tissue. To protect my eyes from the intense light I will have my eyes covered with opaque material or wear laser protective glasses.

Other methods have been used to treat these vessels, including other lasers, excision, electrocautery, and sclerosing agents.

The sensation of the light is uncomfortable and may feel like a moderate to severe pinprick or burst of heat that lasts for only a few seconds. If Dr. Rotter elects to use some form of local anesthesia, the options will be discussed.

1. I am aware that no guarantee of complete removal is made. Initial \_\_\_\_\_
2. The treatment will vary depending on the type, age, and color of the lesion. Initial \_\_\_\_\_
3. **MULTIPLE TREATMENTS ARE NECESSARY AND COMPLETE CLEARING OF THE LESION MAY NOT BE POSSIBLE. THE LESION MAY ALSO RECUR AFTER A PERIOD OF TIME.** Initial \_\_\_\_\_
4. I have been informed of the possible complications:
  - Blistering Initial \_\_\_\_\_
  - Scarring Initial \_\_\_\_\_
  - Hyperpigmentation (darkening of the skin) Initial \_\_\_\_\_
  - Hypopigmentation (lightening of the skin) Initial \_\_\_\_\_
5. I am aware that I must not have a tan before or after receiving laser treatments. Initial \_\_\_\_\_
6. I am aware that swelling may occur around the treated area. Initial \_\_\_\_\_
7. I acknowledge that I must not be pregnant when I am receiving laser treatments. Initial \_\_\_\_\_
8. Immediately following the laser treatment the treated area will be very delicate and appear bruised and may have a blue/gray discoloration. This discoloration is called purpura and may last 7-14 days. There may be some crusting that requires wound care. Initial \_\_\_\_\_
9. Not adhering to proper skin care treatment following the laser treatment can increase the chance of scarring or skin textural changes to the treated area Initial \_\_\_\_\_
10. If complications do occur, it is my responsibility to inform, and show the area to, Dr. Rotter. Initial \_\_\_\_\_

This consent is a written confirmation of a discussion I have had with Dr. Steven Rotter and/or his assistant regarding laser therapy using the Pulsed Dye Laser.

I certify that I have read and understood all information that has been presented to me before signing this form.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or person legally authorized to consent for patient)

Witness: \_\_\_\_\_ Time: \_\_\_\_\_  
(To patient's signature)