

Dr. Peter Bray – Certified Plastic Surgeon, MD, MSc, FRCS (C)
Phone: (416) 323-1330 | Fax: (416) 323 – 9397 | info@drbrayplasticsurgery.com | www.drbray.ca
66 Avenue Rd., Upper level, Toronto, ON M5R 3N8

Instagram icon @drbrayplasticsurgery

Laser Hair Removal Consent

Laser hair removal is a procedure that gradually and permanently reduces hair growth on average by 80-90%. Laser hair removal success is dependent on the cycle of the hair as only anagen or active phase will be treated. Therefore, multiple treatments are needed as the hair goes in and out of active and dormant stages. The cycle of the hair growth differs depending on the area. A schedule of regularly spaced intervals will be discussed with you so you will get the maximum benefit of your treatment. Reduction of hair is also dependent on your skin type and ethnic background and treated accordingly to provide for the safest reduction of hair.

Taking all of this into consideration, it may take anywhere from 6-12 treatments for your permanent reduction of hair and touch up treatments are suggested every 6-12 months. It is common to feel slightly sunburned in the treated area, have redness and mild swelling. Do not expose the area to high temperatures following treatment and it is imperative that you avoid direct sun exposure for 2-4 weeks. Although rare, complications can occur such as blistering, pigment changes, and scarring.

I have read the above information and acknowledge:

- I do not have the following conditions: pregnancy, photosensitivity disorder, diabetes, bleeding disorder, seizure disorder triggered by light, active cold sore in the treatment area.
- I have not been tanning (artificial or creams included) in the past 2-4 weeks
- I have not waxed, tweezed, threaded, bleached, or used depilatory with in the past 4 weeks of each treatment
- I have not taken Accutane in the past year.
- I have not used retinol products in the past week.
- I am not taking any photosensitive medication-s such as antibiotics.

After discussing the above, we reserve the right to withhold treatment until it is in your best interest to resume.

Patient Signature: _____ Date: _____

Healthcare Provider: _____ Date: _____