	Affix Patient Label	
	Patient Name:	DOB:

Informed Consent Latisse® Treatment

This information is given to you so that you can make an informed decision about having **Latisse® Treatment.**

Reason and Purpose of the Product:

Latisse® is a prescription treatment for inadequate or not enough eyelashes. The medical term is hyptrichosis. Latisse® is used to grow eyelashes.

Response of eyelash growth to Latisse® is gradual. Results are usually seen after 8 weeks of daily application. Full benefits usually occur after 16 weeks. Lashes will gradually return to the way they were if this treatment is stopped.

Benefits of this product:

You might receive the following benefits. Your professional cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Longer, thicker eyelashes.

Risks of Product:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your provider cannot expect.

- Itching sensation in the eyes or eye redness, this may occur right after use. This is not an allergic reaction. It usually lasts for a short period of time.
- Darkening of the eyelid skin, this may go away on its own.
- Increase in brown pigmentation of the colored part of the eye. This can be permanent.

Risks associated with smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

____
____
____
____

Alternative Treatments:

Other choices:

- Do nothing.

General Information

- **You should not be pregnant, or trying to get pregnant while using Latisse®.**
- **You should not use Latisse® if you are currently breastfeeding.**
- **If you have a history or diagnosis of glaucoma or elevated intraocular pressure, talk to your professional to decide if you should use Latisse®**
- **Contact lenses should be removed before using the solution. They can be reinserted 15 minutes after using. Tell your eye care specialist that you are using Latisse®. Tell anyone doing an eye pressure screening that you are using Latisse®.**

BRONSON	Affix Patient Label
	Patient Name: DOB:

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with Cosmetic Skin Care Registered Nurse or Medical Assistant. My questions have been answered.

I want to have this procedure: **LATISSE® Treatment**

Patient Signature____Date:_________Time:_________

Relationship: ☐Patient/Parent of minor ☐Closest relative (relationship) ☐Guardian/POA Healthcare

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: ____Date__________Time__________

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention. I have answered questions, and the patient has agreed to procedure.

Provider/Cosmetic Skin Care RN/MA
Signature:_______________________________________ Date:____________ Time:__________

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: ____

____ Area(s) of the body that will be affected: ____

____ Benefit(s) of the procedure: ____

____ Risk(s) of the procedure: ____

____ Alternative(s) to the procedure: ____

OR

____ Patient elects not to proceed: ______________________________ Date:_________ Time:__________

(patient signature)

Validated/Witness:____ Date:_________ Time:__________