

CO₂ LASER TREATMENT CONSENT FORM

(For Acne Scars / Skin Resurfacing / Pigmentation / Wart or Mole Removal)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____



1. Procedure Description

CO₂ Laser treatment is a skin resurfacing and rejuvenation procedure that uses a carbon dioxide laser to remove damaged skin layers and stimulate collagen formation. It is commonly used for acne scars, wrinkles, warts, moles, pigmentation, and skin texture improvement. The procedure is performed under local anesthesia.

2. Purpose of Procedure

The purpose of this treatment is to improve the appearance of scars, fine lines, and uneven skin texture, and to promote new, healthy skin regeneration.

3. Possible Risks and Side Effects

I understand that the following risks and side effects may occur:

- Redness, swelling, or mild burning sensation post-procedure.
- Temporary scab formation and crusting during healing.
- Post-inflammatory hyperpigmentation or hypopigmentation.
- Temporary itching, tightness, or peeling of the treated area.
- Rarely, infection, scarring, or prolonged redness.
- Delayed healing if post-care instructions are not followed.

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Avoid direct sun exposure, chemical peels, or active topical creams for at least one week prior.
- Inform your doctor if you are on isotretinoin, blood thinners, or have any skin infections.
- Do not wear makeup or apply any cream on the day of treatment.

Post-Procedure:

- Keep the treated area clean and moisturized with the prescribed ointment.
- Do not rub, scratch, or pick scabs.
- Avoid hot water, steam, gym, or swimming for 5-7 days.

- Strictly use sunscreen (SPF 30+) to avoid pigmentation.
- Expect redness for 5-10 days; healing time may vary depending on depth of treatment.

5. Acknowledgment

I acknowledge that the nature, purpose, benefits, and possible risks of CO₂ Laser treatment have been explained to me. I understand that multiple sessions may be needed for best results and that downtime of a few days is expected. I confirm that I have disclosed all relevant medical history and medications. I voluntarily consent to undergo CO₂ Laser treatment.

6. Consent

Patient Name: _____

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Signature: _____

Date: _____

Witness Name: _____

Signature: _____

Date: _____

Doctor's Name & Signature: _____

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