

FRECKLE REMOVAL CONSENT FORM

(Using Q-Switched Laser / Chemical Peel / Laser Toning Method)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____



1. Procedure Description

Freckle removal is a cosmetic procedure that aims to lighten or remove pigmentation spots on the skin caused by sun exposure or genetic factors. The treatment may involve Q-switched laser, chemical peels, or laser toning to target melanin and achieve a more even skin tone. Multiple sessions may be required for optimal results.

2. Purpose of Procedure

The purpose of this procedure is to reduce the appearance of freckles and pigmentation, resulting in clearer, brighter, and more even-toned skin.

3. Possible Risks and Side Effects

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

- Mild redness, warmth, or swelling after the procedure.
- Temporary scabbing or darkening of treated freckles before they fade.
- Post-inflammatory hyperpigmentation or hypopigmentation.
- Dryness or mild peeling of the skin.
- Rarely, infection or scarring if proper aftercare is not followed.
- Uneven or partial response, requiring multiple sessions.

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Avoid sun exposure and tanning for at least one week before treatment.
- Do not use retinoids, exfoliating creams, or bleaching agents 3–5 days prior.
- Inform your doctor about any history of pigmentation disorders or skin sensitivity.

Post-Procedure:

- Keep the treated area clean and apply prescribed ointment or soothing cream.
- Do not pick or scratch scabs; allow them to fall off naturally.
- Avoid direct sun exposure, heat, gym, and swimming for 3–5 days.
- Use sunscreen (SPF 30+) daily to prevent recurrence or pigmentation.
- Follow the recommended session plan for consistent results.

5. Acknowledgment

I acknowledge that the nature, purpose, benefits, and potential risks of freckle removal have been explained to me. I understand that complete removal may not always be possible and maintenance sessions may be needed. I have had the opportunity to ask questions, and all my doubts were clarified. I voluntarily consent to undergo freckle removal treatment.

6. Consent

Patient Name: _____

Signature: _____

Date: _____ 

Witness Name: _____

Signature: _____

Date: _____

Doctor's Name & Signature: _____

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