YOUR WELLNESS CENTER
WEIGHT LOSS, HORMONE REPLACEMENT & MEDSPA

Consent for LATISSE®

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Please initial the following statements below:

_____ I understand the use of LATISSE® (bimatoprost ophthalmic solution 0.03%) is an FDA-approved prescription treatment for Hypotrichosis (inadequate or not enough eyelashes).

_____ LATISSE® is a prescription medication and may not be shared with anyone.

_____ LATISSE® is non-returnable and non-refundable.

Use:

_____ LATISSE® is to be used once a day on the upper eyelid only.

_____ The benefits achieved with LATISSE® continue with daily use of the medication. If LATISSE® is discontinued, the eyelashes will return to their normal state.

Contraindications:

_____ I am not currently being treated for glaucoma.

_____ I am not allergic to bimatoprost ophthalmic solution.

_____ I am not pregnant or lactating.

Risks & Complications:

_____ Possible side effects include eye redness or itching and eyelid irritation. These symptoms are side effects and not allergic reactions.

_____ LATISSE® may cause darkening of the upper eyelid skin which may be reversible.

_____ LATISSE® may cause permanent discoloration of the iris (colored part of the eye) if the drops frequently come in contact with the eye.

_____ I understand it is important to inform my eye care specialist that I am using LATISSE®. I will tell anyone conducting an eye pressure that I am using LATISSE®.

_____ I understand it is possible for hair growth to occur in other areas of my skin that LATISSE® comes in contact with frequently.

_____ I will discontinue use of LATISSE® and contact my health care provider if side effects occur.

I understand the full use of LATISSE® including alternatives, risks, complications, and benefits. I have had all my questions answered.

Patient Signature: _____ Date: _____