



Lakewoodlaser.com

303•202•0927

Name: _____ D.O.B. _____ Ethnicity _____
 Address: _____ Ph.# (H) _____ (W/cell) _____
 City _____ State _____ Zip _____
 Medications: _____ Email address: _____

Informed Consent for Latisse™ (bimatoprost ophthalmic solution) 0.03%

Do you have a known allergy to: bimatoprost ophthalmic solution? Yes No
 Have you been previously diagnosed with eye pressure problems? Yes No
 Are you currently taking medication for eye pressure problems? Yes No
 Do you have risk factors for glaucoma? Yes No
 Do you have an eye infection currently? Or taking meds for an eye infection? Yes No
 Do you have (or have you had) cataracts, irritated eyelids, dry eye,
 or other eye conditions? Yes No
 Are you pregnant or breastfeeding? Yes No

I have read the Latisse™ information provided to me and understand the nature and purpose of the product. I am aware of how it should be applied. I am aware of the possible side effects and am aware that I should discontinue the product if I develop a new eye condition (trauma or infection), experience sudden decrease in vision, have eye surgery, or develop any eye reactions. If any of these occur, I am aware that I should immediately talk to a doctor about whether to continue using Latisse solution.

No guarantee, warranty or assurance has been made as to the results of using the Latisse™ product. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained.

Name: _____

Signature: _____ Date: _____