

## Pre Operative Form for Laser Hair Reduction

Division of Plastic Surgery  
University Surgical Associates

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Areas to be treated (check all that apply):

\_\_\_\_\_ Axillae

\_\_\_\_\_ Lip

\_\_\_\_\_ Face (specify area) \_\_\_\_\_

\_\_\_\_\_ Neck

\_\_\_\_\_ Legs (specify area) \_\_\_\_\_

\_\_\_\_\_ Back (specify area) \_\_\_\_\_

\_\_\_\_\_ Breast

\_\_\_\_\_ Bikini area

\_\_\_\_\_ Other (specify area) \_\_\_\_\_

I have received and understand the patient information packet regarding the risks, benefits, and alternatives of the hair removal laser and wish to proceed with the treatment of areas listed above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness