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PHOTOSYNTHESIS

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THE DIFFERENCE IS IN THE FLUORESCENCE

Kleresca®

Helping people feel good about their skin

Legal Manufacturer:
FB Dermatology Limited / Kleresca
51 Bracken Road, Sandyford Industrial Estate, Dublin 18, Ireland

Consultation Form for Kleresca® Treatment

Client name: ..... Date of birth: .....

Address: ..... Contact number: .....

Postal code/City: ..... E-mail: .....

Learn more at www.kleresca.com

Kleresca®

Medical history

Please complete the following medical questionnaire*

Do you suffer from any of the following conditions?	Yes	No
Epilepsy or Seizures triggered by light	☐	☐
Acute or Cutaneous Porphyria	☐	☐
Chronic Cutaneous or Discoid Lupus	☐	☐
Photo Sensitive Eczema	☐	☐
Hypomelanism (Albinism)	☐	☐
Hyperpigmentation (e.g. Melasma, Solar Lentigo (age spots), etc.)	☐	☐
Eye Disease or Retinal Abnormalities	☐	☐
Skin conditions or disorders	☐	☐
Cold sores	☐	☐
Migraines	☐	☐

Can you answer yes to any of the questions below?		
Are you pregnant or breastfeeding?	☐	☐
Do you have any health problems or medical conditions?	☐	☐
Are you taking any medication including herbal remedies & non prescription drugs?	☐	☐
Have you recently had any medical treatment or operations (last 6 months)?	☐	☐
Are you due to have any medical treatment or operations (next 6 months)?	☐	☐
Do you use sunbeds or have regular sun exposure?	☐	☐
Are you currently having any other skin treatments?	☐	☐

If 'Yes' to any of the above questions please specify details below:

If the answer is yes to any of the questions above, your practitioner may ask for further details.
*Kleresca/FB Dermatology's suggested list of questions to be considered by the practitioner when determining if Kleresca® is right for their client.
Not intended to be a comprehensive list to be relied on by practitioners.

Practitioner consultation form for patients

Consultation Form for Kleresca® biophotonic treatments*

Treatment type:.....

I confirm that I have answered all the questions to the best of my knowledge and understand that withholding necessary information about my health and medication may increase my risk of experiencing an adverse reaction.

I will inform my Practitioner before every treatment if there has been any change to my circumstances (for example medication taken).

I understand the benefits and likely clinical outcome of Kleresca® treatment and that multiple treatments are necessary to achieve optimal results.

I agree that I have read and understood all the information provided to me by my Practitioner, my questions have been answered satisfactorily by such information and by my Practitioner and I have made an informed decision to have a Kleresca® treatment.

I understand and hereby explicitly consent to the processing of my personal information (including my medical information) by my Practitioner as part of the general record keeping in the relationship between me and my Practitioner. I further consent to the disclosure of my personal information (including my medical information) to Kleresca® and its affiliates as the manufacturer of Kleresca® for the purposes of general analytical purposes towards the real life use, efficacy and safety of Kleresca® aggregated in such a way that I as a person cannot be personally identified in such analytical activities. Such processing will follow applicable data protection laws.

I understand that under applicable data protection laws, I have a right to access my personal information and to request the correction of any error or inaccuracy in relation to my personal information. I understand I also have the right to object to the processing of my personal information in certain circumstances and should I wish to exercise any of these rights I should contact my practitioner.

I hereby acknowledge the Practitioner has explained the treatment to me in detail and outlined the potential side effects. Side effects – seen in some patients – are all transient and may include redness, swelling and hyperpigmentation (bronzing of an area of the skin).

*this consent is between the practioner and the client

Client Name:..... Client Signature: .....

Date:..... Practitioner Signature:.....