



VisionFirst

## LATISSE™ Consent Form

VisionFirst Eye Center

Thank you for purchasing LATISSE™ from VisionFirst Eye Center. To make sure you have the best result possible, we ask that you carefully read and sign this consent form before you use LATISSE™ for the first time.

**TELL YOUR DOCTOR** - LATISSE™ is approved by the Food and Drug Administration (FDA) for the treatment of thin or short eyelashes.

1. If you have a history of abnormal intraocular pressure (IOP), you should inform your eye doctor and only use LATISSE™ with close supervision of your eye doctor.
2. Do not use LATISSE™ solution if you are allergic to one of its ingredients.
3. Inform your eye doctor if you are already using LATISSE™, especially if you have a history of eye pressure problems.
4. You should also tell anyone conducting an eye pressure screening that you are using LATISSE™.
5. Because the effect of applying LATISSE™ to the eyelids of **pregnant or breast feeding** patients is unknown, our eye doctors do not recommend use.

**WARNINGS** - LATISSE™ solution is intended for use on the skin of the upper eyelid margins at the base of the eyelashes.

1. **DO NOT OVERDOSE**. More is not better.
2. **DO NOT APPLY** to the lower eyelid.
3. **DO NOT USE DIRECTLY IN THE EYE**. Although not reported in clinical studies, LATISSE™ use may also cause increased brown pigmentation of the colored part of the eye which is likely to be permanent.

**SIDE EFFECTS** - LATISSE™ solution may cause other less common side effects which typically occur on the skin close to where LATISSE™ is applied, or in the eyes.

1. These include skin darkening, eye irritation, dryness of the eyes, and redness of the eyelids.
2. The most common side effects after using LATISSE™ solution are an itching sensation in the eyes and / or eye redness. This was reported in approximately 4% of patients. Symptoms will subside with continued use.
3. Some patients may experience no change in the eyelash growth with LATISSE™.
4. Hair growth outside of the target area may develop with repeated contact.

**KEYS TO SUCCESS:**

**STEP 1** - Before applying Latisse each night, be sure your face is clean, your makeup and contact lenses are removed. Apply any creams before applying Latisse, but avoid the lid margins. Contact lenses should be removed prior to application and may be reinserted 15 minutes following its administration.

**STEP 2** - Allowing the solution to touch the area below your eye may darken the skin as a result. To help avoid contact with the solution, apply a thin layer of petroleum jelly or other eye cream under your eyes and at the outer corners of your eyes before applying.

**STEP 3** - Remove an applicator from its tray. ONLY use the sterile applicators supplied with Latisse to apply the product. Don't allow the tip of the bottle or applicator to contact surrounding structures, fingers, or any other unintended surface in order to avoid contamination by common bacteria known to cause infections. Holding the sterile applicator horizontally, place one drop of the solution on the area of the applicator closest to the tip but not on the tip.

**STEP 4** - Immediately draw the applicator carefully along the skin at the base of the upper lashes (where the lashes meet the skin) going from the inner part of your lash line to the outer part. Do not apply in your eye or to the lower lid because excess hair growth outside the treatment area may occur.

**STEP 5** - Blot any excess solution beyond the eyelid with a tissue.

**STEP 6** - Dispose of the applicator after one use.

**STEP 7** - Repeat for opposite eyelid, using a new sterile applicator to help minimize any potential for contamination from one eyelid to another.

**CONSENT** - I understand that the doctors of VisionFirst Eye Center are consultants and are acting as a teaching center for Allergan, the manufacturer of Latisse™. Full prescribing information has been provided to me by my eye doctor.

I agree to hold (examining doctor's name) \_\_\_\_\_, and VisionFirst Eye Center harmless for not meeting my expectations since I am choosing to receive this treatment.

**This product is not returnable. All sales are final.**

Print Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_