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