BEAUTY WITHIN
MEDICAL AESTHETICS · SYNERGY CENTRE

**Dr. Maria Tetelbaum**
1635 Hyde Park Road London, ON N6H 5L7
519-266-3642
beautywithin@sclondon.ca
www.beautywithin.ca

Latisse™ (bimatoprost ophthalmic solution) 0.03%

# LATISSE® Eye Evaluation & Consent Form

## HEALTH/EYE HEALTH HISTORY

**Date:** _____

**First Name** (& preferred): _____ **Last Name:** _____

**Date of Birth:** D _____ M _____ YR _____ **Age:** _____ Pronouns: She/Her He/Him Other: _____

Address: _____ City/Town:_____ Postal Code: _____

Telephone: (_____) _____ May we leave a voicemail? YES / NO

Email: _____ Occupation: _____

**OHIP** (health card) #: _____ Version Code: _____
(*Will only be used if medical assessment/eye exam and/or treatment is provided.)

How did you hear about us? _____

**Date of last eye exam:** _____ Eye Doctor (name & phone #): _____

At your last eye examination, were you told that you had any problems with your eyes? **Y / N** If yes, please explain: _____

Your eye colour: _____ _____

Do you have a history of **glaucoma or increased pressure** inside the eye? **Y / N**

Does anyone in your immediate family have a history of glaucoma or increased pressure inside the eye? **Y / N**

Do you wear eye glasses or contact lenses? **Y / N** Have you had any injuries/surgeries to the eye/eyelids? **Y / N**

Do you now, or have you ever, had any visual problems with one or both eyes? **Y / N**

Are you bothered by “dry eyes”? **Y / N** Do you have overly “watery eyes”? **Y / N**

Do you have “sensitive eyes”? (i.e.: become irritated easily, itchy, red, swell excessively) **Y / N** If yes, please describe:

_____

Do you use any eye drops/eye medications of any kind? **Y / N** If yes, please explain: _____

Do you have any **allergies**/sensitivities? **Y / N** If yes, please explain: _____

Current **health conditions**/diagnoses (overall health):

_____

Please list any **current medications** including vitamins, herbal supplements (dosage not required)

_____

Are you planning a **pregnancy** within the next year? **Y / N**

Have you ever used Latisse® or any products marketed for lash growth/thickening? **Y / N** If so, which product? _____

## MEDICATION INFORMATION (*please read)

Latisse® solution (bimatoprost ophthalmic solution) 0.03% is indicated to treat hypotrichosis (inadequate or deficiency of hair) of the eyelashes by increasing their growth, including length, thickness, and darkness. Latisse® is believed to affect the growth (anagen) phase of the eyelash hair cycle by increasing the length of the growth phase and increasing the number of hairs along the eyelid margin. The medication is applied once each night along the upper lash line only. The effect of this medication is gradual, but most patients see improvement by 2 months. The effect of this medication is not permanent. If you stop using this medication, your eyelashes will gradually return to their original appearance. Continued use is required to maintain desired results. Results are not guaranteed.

Common side effects after using Latisse® are an itching sensation in the eyes and/or eye redness (reported in approximately 4% of patients). Less common side effects typically occur on the skin close to where Latisse® is applied, or in the eyes. These include eye

irritation, dryness of the eyes, redness of the eyelids, and skin darkening which may be reversible. Latisse® use may also cause increased brown pigmentation of the coloured part of the eye (the iris) which is likely to be permanent. It is possible for hair growth to occur in other areas of your skin that Latisse® frequently touches. There may be other possible side effects/complications not known at this time.

If you develop a new ocular condition (e.g., trauma or infection), experience a sudden decrease in vision, have eye surgery, or develop any reactions, particularly conjunctivitis and eyelid reactions, you should immediately seek your physician's advice concerning the continued use of Latisse®.
You should inform your physician if you are using LATISSE® especially if you have a history of eye pressure problems. If any eye surgery is planned, inform your ophthalmologist that you are using Latisse®. Inform anyone conducting an eye pressure examination that you are using Latisse®.

Do **not** use Latisse® if you are allergic or hypersensitive to bimatoprost (LumiganR) or any other ingredient in this product.

Latisse® is **not** to be administered if you are pregnant or breastfeeding.

This product is non-returnable.

****Please *initial* (do not check) that you understand and agree with the statements below:****

_____ I do **not** have glaucoma and I have disclosed my general/eye specific health history to the best of my knowledge.
_____ I am **not** pregnant or breastfeeding.
_____ I am aware Latisse® is a prescription medication and I am responsible for reading the package insert before use.
_____ I have been given a copy of the ***Latisse® Instructions For Use*** sheet and understand the steps of application.
_____ I have read and understood ALL of the information provided within this **2** page document, and am aware of and accept the potential risks/benefits of using/not using Latisse® . I have had sufficient opportunity to discuss my concerns/questions with the physician or nurse.
_____ This consent is considered valid for subsequent treatments unless revoked in writing.

Dated: _____

_____
**PATIENT** Name (printed)

_____
Signature
(patient or legal guardian)

Dated: _____

_____
Witness/Provider Name (printed)

_____
Signature

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# Latisse® Instructions For Use

(for patient to keep)

STEP 1. **Before Applying**

Before applying Latisse® (bimatoprost ophthalmic solution) 0.03% each night, ensure your face is clean, makeup and contact lenses are removed, and any other facial care products have already been applied.

STEP 2. **Prepare the Applicator**

Remove an applicator from its tray. Then, holding the sterile applicator horizontally, place one drop of Latisse® solution on the area of the applicator closest to the tip but not on the tip.

STEP 3. **Apply to Skin Using Applicator**

Immediately draw the applicator carefully along the skin at the base of the upper eyelashes (where the eyelashes 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.

STEP 4. **Blot Excess**

The upper lid margin in the area of lash growth should feel lightly moist without runoff. Blot any excess solution runoff outside the upper eyelid margin with a tissue or other absorbent cloth.

STEP 5. **Dispose of Applicator**

Dispose of the applicator after one use. Repeat for opposite eyelid, using a new sterile applicator to help minimize any potential for contamination from one eyelid to another.

## *IMPORTANT REMINDERS*

- Only use the sterile applicators supplied with Latisse® to apply the product.
- Apply Latisse® daily for 16 weeks. You should **not** reduce or stop application when you first notice results.
- Do **not** allow the tip of the bottle or applicator to touch fingers or any other unintended surface, as contamination by common bacteria is known to cause infections.
- Remove contact lenses prior to applying Latisse®. Contact lenses may be reinserted 15 minutes afterwards.
- Do **not** apply in the eye or to the lower eyelash line.
- It is possible for hair growth to occur on other areas of the skin that Latisse® solution frequently touches, so blot the excess as directed.
- Additional applications of Latisse® will not increase the growth of eyelashes, so please only 1 application per day (at night).
- If you miss a dose, do not play“catch-up.” Just apply Latisse® solution the next night as usual.
- Upon discontinuation of treatment, eyelash growth is expected to return to its pre-treatment level.

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**Latisse® is a prescription medication - please read the package insert before use.**

***Please contact the clinic immediately** if you experience side effects beyond one week or if you develop a new ocular condition (e.g., trauma or infection), experience a sudden decrease in vision, have eye surgery, or develop any reactions, particularly conjunctivitis and eyelid reactions.

**Please call 519-266-3642 should you have any concerns.**