


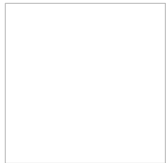
Isotretinoin Consent Form

| | | | | | |
|--------------|---|----------------|---------------|---|--------------------|
| Patient Name | : | Alston Rebello | Emirates ID | : | 784-1991-2906159-3 |
| File No | : | 17 | DOB | : | 1996-06-20 |
| Nationality | : | Indian | Date | : | 2024-03-01 |
| Gender | : | Male | Doctor's Name | : | test test |

Please Initial:

- ☐ I, the undersigned declare that I have been fully informed of details of the precautions to be taken during the isotretinoin therapy period.
- ☐ I must prevent pregnancy during therapy and 1 month post therapy.
- ☐ Child malformation is expected to be seen in case of pregnancy during the treatment phase and a month after. Strictly, pregnancy must be prevented to avoid this
- ☐ I do understand I must take contraceptives seriously and regularly during therapy and one month after.
- ☐ In case of pregnancy I must inform my doctor immediately.
- ☐ I understand the consequences of not following the doctor's orders to prevent pregnancy during isotretinoin therapy.
- ☐ I hereby do not hold the doctor responsible to having not to follow the precautionary measures.
- ☐ This consent form is valid for 6-9 months course period, and I will alert the staff if there are any future changes to my medical history, or if I become pregnant.

I hereby give my consent and authorization voluntarily and release VISION MEDICAL & DENTAL CENTER (Abu Dhabi) from any claims, implied or stated that I have or may have in the future with this treatment regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

| | |
|---|---|
| Sign here, only if all of your questions have been answered to your satisfaction | |
| Patient | Doctor |
|  |  |
| Patient Name Alston Rebello Date 2024-03-01 | Doctor Name test test - Laser (1) Date 2024-03-01 |