TULANE SCHOOL OF MEDICINE – DEPARTMENT OF DERMATOLOGY

TOPICAL BIMATOPROST FOR CHEMICAL BLEPHAROPLASTY: CONSENT FOR MEDICAL PHOTOGRAPHY

Purpose:

For medical records, consultation, teaching, and publication

I understand that photographs will be made and recorded of me. I understand the term "medical images" as used here includes electronic as well as printed images. I understand and agree that the nature of use of these images is for purposes of medical records, consultation, teaching, and publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

The use of medical images for medical records includes recording and saving images in the print and or digital records for office use. The use of medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions. The use of medical images for teaching purposes includes the use of my images for teaching medical students, medical residents, practicing physicians and other healthcare professionals. The use of medical images for publication includes my images or recordings in print or online medical journal publications. I understand that if I allow my images be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care.

_____ I consent to allow medical photographs for all purposes described above

_____I do not provide consent to allow recording or saving of medical photographs.

Signature of patient: _____

Date_____ Time_____

Physician Signature:_____

Date_____Time_____

Witness: _____

Date Updated: 8/4/2016
Version: 1

TULANE SCHOOL OF MEDICINE – DEPARTMENT OF DERMATOLOGY

TOPICAL BIMATOPROST FOR CHEMICAL BLEPHAROPLASTY: CONSENT FORM

You are being asked to take part in a research study of how using topical bimatoprost 0.03%, currently FDA approved for eyelash enhancement, might improve dermatochalasis or a "droopy eyelid." We are asking you to participate in this study because you have some degree of dermatochalasis. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about:

The purpose of this study is to see if using topical bimatoprost in the FDA-approved application will improve drooping upper eyelids. A total of 15 patients will be recruited.

What we will ask you to do:

If you agree to be in this study, we will provide topical bimatoprost 0.03% (Latisse) to be used at home every night. We will ask that you come in monthly for 4 months for a clinic visit, during which we will administer a survey and ask about any side effects. We will take photographs of your eyebrows and eyes during each visit.

Risks and benefits:

The current application of this medication is for eyelash enhancement; you can expect to see longer and fuller lashes as a result.

There is a potential for changes of the upper eyelid that could improve drooping. If change occurs, it is usually reversible once the medication is stopped.

Risks are minimal. Potential side effects include itching sensation of the eyes or eyelids, intraocular pressure effects, eyelid skin redness or darkening, iris darkening, unexpected hair growth or eyelash changes.

The data will be retained by the researcher without identifiers for possible use in a future project, which will be consistent with the original research purpose.

Taking part in this study is voluntary. You are free to withdraw at any time.

Contact information:

You can ask us questions at any time.

If you have any questions about the study or any problems with the study, you can call the Principal Investigator, Megan Couvillion, at 504-473-2915.

If you have any questions about the study but want to talk to someone who is not part of the study, you can call the Tulane University Human Research Protection Office (HRPO) at (504) 988-2665."

Signature:

If you understand this study and you are willing to participate, please sign below:

_____

Subject Name

_____ _____

Subject Signature Date

_____ _____

Witness Date

<u>Signature of Investigators or Responsible Individual:</u>

"To the best of my ability, I have explained and discussed the full contents of the study, including all of the information contained in this consent form. All questions of the research subject have been accurately answered."

_____

Investigator/Person Obtaining Consent Name

_____ _____

Signature Date

Date Updated: 8/4/2016
Version: 1