

INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

Name _____

Date of Birth _____

Address _____

Phone _____



The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox® and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) radial lip lines (smokers lines), e) head and neck muscles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer. **Initial** _____

RISKS & COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1. Post treatment discomfort, swelling, redness, and bruising. 2. Double vision. 3. A weakened tear duct. 4. Post treatment bacterial, and/or fungal infection requiring further treatment. 5. Allergic reaction. 6. Minor temporary droop of the eyelid(s) in approximately 2% of injection, this usually lasts 2-3 weeks. 7. Occasional numbness of the forehead lasting up to 2-3 weeks. 8. Transient headache and 9. Flu-like symptoms may occur. **Initial** _____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant, and I am not trying to get pregnant. I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenia gravis, multiple sclerosis, lambert-eaten syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have ben fully explained to me. **Initial** _____

Client Signature _____ **Date** ____/____/____