Anti-wrinkle Consent - Duplicate

BOTOX CONSENT

[FNAME] [LNAME] [DOB] [DATE] [FULLADDRESS]

Before undergoing any clinical procedure it's a legal requirement that you read and sign the following consent. This disclosure is not meant to scare or alarm you; it is simply an effort to ensure you have been fully informed, so you may give or withhold your consent to this procedure.

I, [ANAME] have been fully informed by my physician of the following conditions relating to the treatment of Botox. I have answered all of the questions regarding my health, skin and medical status correctly and to the best of my knowledge. I am aware that it is my responsibility to inform my physician if there are any changes to medication or to my general health. I realise that withholding information may lead to complications.

The cost of treatment has been advised and specific treatment parameters have been discussed and established. I understand the aim of Botox treatment is to improve lines and winkles by breaking excessive habit of muscle movement in specific areas. I am aware it will not create perfection and eradication of dynamic lines on the face. I understand that no guarantee has been made to me as to result or cure.

Practice of medicine and surgery is not an exact science; therefore even reputable physicians cannot guarantee results. I am aware that it is possible that the result of treatment may not reach my full expectations or goals. I am aware that various conditions may require additional or different procedures than those originally planned.

Treatment contra-indications have been discussed and I understand that I should not receive Botox treatment if any of the following applies:

Treatment contra-indications

☐ Neuromuscular transmission disorders

☐ Known hypersensitivity to any ingredient in the formulation of Botox i.e. human albumin

☐ Coagulation disorders or use of anticoagulant i.e. aspirin, warfarin

☐ Unrealistic expectations

☐ Unrealistic fear of systemic botulism I realise that, as in all medical treatment, complications or a delay in recovery time is a possibility.

☐ Myasthenia Gravis, Eaton-Lambert syndrome

☐ Pregnant or lactating

☐ Use of amino glycoside antibiotics or streptomycin within 3 days of Botox treatment.

☐ Lack of patient co-operation

If this occurs I understand that there may be a need for additional treatment, it could also result in an economic loss to me due to my inability to return to normal activities as soon as anticipated. I have discussed and I am aware of the possible risks and complications relating to Botox:

Possible risks and complications

☐ Potential swelling, bruising, bleeding, blood clots in veins and lungs (extremely rare) and allergic reactions.

☐ Less than 10% of patients experience temporary discomfort from redness and mild swelling which resolves transiently within 48 hours.

☐ On occasions Botox does not fully take, resulting in an uneven or incomplete response to treatment. In this case a minor touch up may be required in ensuring weeks.

☐ I hereby give permission to my physician to take clinical photographs for diagnostic purposes and to enhance the medical record. I can confirm I have read and understood the Botox information and after care sheet.

☐ I agree to adhere to all of the advice and instructions given before, during and after the procedure. I will notify my physician of any problems following the procedure.

☐ I certify that I have discussed all aspects of the treatment and have been given the opportunity to ask any questions or raise any concerns. I confirm all questions have been answered implicitly to my satisfaction.

☐ I hereby authorise my physician to administer the treatment and agree to hold him free and harmless from any claims, refunds or suits damages for any injury or complications whatsoever

☐ I hereby certify that I have discussed all of the above with the patient. I have offered to answer any questions regarding the procedure and believe the patient fully understands what I have explained and answered. which may result in the treatment.

Patient Name: ____________________

Patient Signature:

Date: ____________________ dd / mm / yyyy **Practitioner Name:** ____________________