Kybella

KYBELLA

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DisclaimerProcedure Overview Kybella (deoxycholic acid) is an injectable treatment used to improve the appearance of moderate to severe fat below the chin (submental fullness). The active ingredient destroys fat cells, resulting in a noticeable reduction in fullness under the chin. Intended Benefits Reduction of submental (under-chin) fat Improved chin and jawline contour Non-surgical alternative to liposuction Risks and Possible Side Effects While Kybella is generally well tolerated, risks and side effects may include: Swelling, bruising, redness, or numbness at the injection site Temporary discomfort or pain Firmness or hardness in treated areas Difficulty swallowing Nerve injury leading to an uneven smile or facial muscle weakness (rare) Infection or allergic reaction (very rare) Contraindications This treatment may not be suitable if you: Have an active infection in the treatment area Are pregnant or breastfeeding Have difficulty swallowing (dysphagia) Have had surgery or cosmetic treatments in the neck or chin area Have any bleeding disorders or are on anticoagulant medications A full medical consultation must be completed before treatment. Pre-Treatment Instructions Avoid alcohol and nonessential blood thinning medications (e.g. aspirin, ibuprofen, fish oil) for 3–5 days before treatment Do not undergo treatment if you have an active infection or inflammation in the area Inform your practitioner of all medications and supplements you are taking Eat a small meal and hydrate before your appointment to reduce light-headedness Aftercare Instructions Apply a cold compress to reduce swelling and discomfort Avoid touching or massaging the treated area Sleep with your head elevated for the first few nights Avoid strenuous activity, alcohol, and heat exposure (e.g. saunas, hot showers) for 24–48 hours Swelling and firmness may persist for up to 2 weeks Attend all follow-up appointments as advised by your practitioner Results typically appear gradually over 4–6 weeks Informed Consent and Photography I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: the aims/motivations for having the procedure and the desired outcome the risks inherent in the procedure the risks inherent in refusing the procedure the risks specific to me the expected benefits of the treatment the potential disadvantages of the treatment alternative procedures and their pros and cons – including the option of no treatment at all any uncertainties about and the likelihood of success of the procedure any follow-up treatment that may be required Clinical Photographs and Videos: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records. I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

☐ I will retain this information throughout the course of my treatment and refer to it as required