BOTOX, FILLERS & PEELS
CONSENT FORM

I_____of_____

_____

give consent to undergo the following treatment _____

on this date _____

I understand that I may be required to have a follow-up consultation at 2 weeks, and that I may be required to have photographs taken before, during and after treatment for my medical records.

*For Botox® treatments, I understand the product is injected with a small needle into a muscle, with the aim of inhibiting the underlying muscle contraction therefore improving but not eliminating facial lines. I have been informed about the treatment, procedure, indications, expected results and possible side effects. I understand that I may experience swelling, redness, tenderness, double vision, drooping of the eyelids (blepharoptosis), headache, pain and / or bruising either temporarily or permanently. An adjacent muscle may be weakened for several months after injection and muscles affected will not contract thereby reducing my facial expressions.

*For filler injections, I understand that I am being injected with a product containing hyaluronic acid which will gradually dissolve over a period of time. This time period is unpredictable and may be a few months or several months. I accept that additional treatments may be necessary to maintain or achieve the desired effect which may or may not be possible to achieve. I understand that the potential adverse effects of hyaluronic acid injections include bruising swelling or pain at the site of injection; allergies which are rare but may lead to painful, itchy, red patches on the skin; palpability and visibility of the filler, infections and its consequences, lumps that may be palpable or painful, and triggering of facial herpes simplex infections (cold sores). I have told my practitioner if I have previously suffered from cold sores.

*For chemical peels, I understand that I am being treated with a skin irritant that will cause peeling of the top layers of my skin over the next several days. My skin will require moisturising once the peeling starts and this may be associated with mild to moderate discomfort, redness of the skin, miliary cysts, activation of cold sores, temporarily increased skin wrinkles, hyperpigmentation, hypopigmentation, scarring, bleeding, bruising, incomplete resolution of symptoms and the need for multiple treatments. I understand the need for high sun protection factor application for two weeks after the peel. For all treatments, I understand that the actual degree of improvement cannot be predicted or guaranteed and I understand that the effect will gradually wear off and side effects and complications may occur. I understand and accept that this treatment is not an exact science and that no guarantees can be or have been made concerning the expected results in my case. I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure.

I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur. For all treatments I accept there are risks of infection, bruising, scarring, overcorrection, under correction, and asymmetry. I have informed my practitioner of the degree of treatment I would like to have but accept that there is no guarantee of what I will achieve.

I am not pregnant and am not breast feeding. I have never had an allergic reaction to any product being administered including local anaesthetics. I am not currently suffering from cold sores. If I suffer from cold sores I have told the practitioner who has given me a prescription for antiviral medication which I agree to take as prescribed. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered and for full informed consent.

I do * /do not * give consent to allow photographs of me taken to be kept under my file.

Patient signature and name _____

Date _____

Practitioner signature and name_____

Date _____