

# BOTULINUM TOXIN INFORMED CONSENT FORM

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

## PURPOSE

The purpose of this form is to provide written information regarding the risks, benefits and alternatives of the administration of BOTULINUM TOXIN A (Botox, Xeomin, Dysport), to be referred to as "Botox". Botox is used in the correction of mild to moderate facial lines, wrinkles, muscle tension and headaches related to muscular movement. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether to proceed with the procedure. 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.

## PROCEDURE

Botox is a neurotoxin produced by the bacterium Clostridium A. Botox can relax the muscles of the face and neck which cause wrinkles associated with facial expressions or facial pain. Whether for cosmetic or therapeutic treatment, botox can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear.

The most frequently treated areas are:

- A) Glabella (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, neck and jaw 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.

## RISKS AND COMPLICATIONS

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.

1. Post treatment discomfort, swelling, redness, and bruising. Most people have lightly swollen pinkish bumps at the injection site for a few hours or even several days.
2. Minor ptosis (drooping) of the eyebrow or eyelid; occurs in approximately 2% of injections, this usually lasts 2-3 weeks. While local weakness of the injected muscles is representative of the expected pharmacological action of botox, weakness of adjacent muscles may occur as a result of the spread of the toxin.
3. In some cases, ptosis may lead to the inability to blink, double vision, weakened tear duct, and corneal exposure.
5. Post treatment bacterial, and/or fungal infection requiring further treatment.
6. Allergic reaction.
7. Occasional numbness of the forehead lasting up to 2-3 weeks.
8. Transient headache.
9. Flu-like symptoms may occur.

## TREATMENT ALTERNATIVES

This is a voluntary cosmetic/therapeutic procedure. No treatment is necessary or required. Alternative treatments include (but are not limited to) facial resurfacing treatments, laser therapy, chemical peels, dermal fillers, etc.

## DERMAL FILLER INFORMED CONSENT FORM

### PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

### RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

### PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the doctor and/or practice harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial \_\_\_\_

### RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 3 – 10 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the results are satisfactory or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the treated muscles as before while the injection is effective, but that this will reverse after a period of months at which time re-treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area(s) of the injections for the 2 hours post-injection period.

Initial \_\_\_\_

Please initial the following:

\_\_\_\_\_ The details of this procedure have been explained to me in terms I understand.

\_\_\_\_\_ Alternative methods and their benefits and disadvantages have been explained to me.

\_\_\_\_\_ I have informed the doctor or nurse of all my known allergies, including allergies to latex.

\_\_\_\_\_ I have informed the doctor or nurse of all medications I am currently taking including prescriptions, over the counter medications/remedies, herbal therapies and any other.

\_\_\_\_\_ I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.

\_\_\_\_\_ Prices are subject to change. The pricing I receive during this treatment is only for today's treatment. Any additional treatments, products or services will be billed at rates effective at time of the additional treatments.

\_\_\_\_\_ I am not currently pregnant or nursing.

\_\_\_\_\_ I do not have any significant neurologic disease including but not limited to Myasthenis Gravis, Multiple Sclerosis, Lambert-Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS), or Parkinson's.

\_\_\_\_\_ I do not have any allergies to the toxin ingredients, or to human albumin.

\_\_\_\_\_ I have been advised to seek immediate medical attention in the event of vision, swallowing, speech, or respiratory disorders.

\_\_\_\_\_ I certify that I have read and understand this agreement and that all spaces for initials were filled prior to my signature.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The

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procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered to my satisfaction. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I certify that I have explained the nature, purpose, benefits, risks, complications and alternatives of the proposed procedure to the patient. I have answered fully, and I believe that the patient fully understands what I have explained.

DOCTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_