BOTULINUM TOXIN A CONSENT FORM

Finesse Aesthetics

Subtle Solutions for Smoother Skin

PATIENT PERSONAL AND CONTACT DETAILS

Name: _____

Address: _____

Phone: _____

Email: _____

D.O.B _____

MEDICAL HISTORY

- Is there any chance you could be pregnant? _____ Yes/No
- Are you breastfeeding? _____ Yes/No
- Are you taking any medication including "over the counter" medication and/or supplements?
  If yes – please detail
  _____ Yes/No
- Have you taken aspirin, warfarin or ibuprofen in the last week? _____ Yes/No
- Are you due to start any medical treatment within the next 4 weeks?
  If yes – please detail_____ Yes/No
- Are you due to have any operations? If yes – please detail _____ Yes/No
- Have you ever been diagnosed with Myasthenia Gravis or Eaton Lambert Syndrome? ___ Yes/No
- Have you ever suffered from any long term medical condition?
  If yes – please detail
  _____ Yes/No
- Do you have any allergies? If yes - please detail _____ Yes/No
- Have you ever had an anaphylactic reaction? If yes – please detail _____ Yes/No
- Have you ever had facial surgery? If yes – please detail _____ Yes/No
- Have you had any procedures in your facial area? (e.g. laser treatment, skin peels, IPL skin resurfacing, plastic surgery, Injury ? If yes – when? _____ Yes/No
- Have you previously had aesthetic treatments? If yes – when? _____ Yes/No
- Have you previously received Botulinum Toxin A treatment? If yes – when? _____ Yes/No
- Have you ever had any problem following Botulinum Toxin Type A treatment?
  If yes - please detail _____ Yes/No
- Do you smoke?_____ Yes/No
- Have you drank alcohol in the last 24 hours? _____ Yes/No

I confirm that I have answered to the best of my ability

Name:

Signature:

Date:

INFORMED CONSENT – BOTULINUM TOXIN TYPE A

I confirm that Sarah Newey who uses Botulinum Toxin Type A for cosmetic treatments, has given me sufficient information to enable me to understand the use of the product. I have received information regarding the products contraindications and possible side effects. I have been given the opportunity to ask questions about the proposed treatment. When completing the medical history questionnaire, I have answered the questions fully and to the best of my ability. I have also given further details relating to my medical history when asked.

I confirm that I have been informed that Botulinum Toxin Type A is injected into the skin to correct lines and wrinkles (in certain areas this treatment is used off licence).

I confirm that I have been informed that, like all medicine, Botulinum Toxin Type A can produce some unwanted effects. Adverse reactions possibly related to the spread of toxin distant from the site of administration have been reported very rarely with Botulinum Toxin (e.g. muscle weakness, difficulty to swallow or pneumonia due to unwanted food or liquid in the airways). In general, adverse reactions occur within the first few days following injection and are temporary. Most adverse events are of mild to moderate severity. As expected for any injection procedure, pain/burning/stinging, swelling, bruising and/or bleeding may be associated with the use of the needle. Speak to your practitioner if you are worried about this.

Common side effects (classified as more than 1 out of 100 persons and less than 1 out of 10) - headaches ♦ drooping eye lid ♦ skin redness♦ localised muscle weakness ♦ face pain

Uncommon side effects (classified as more than 1 out of 1,000 persons and less than 1 out of 100)- infection ♦ anxiety ♦ numbness ♦ dizziness ♦ inflammation of the eyelid ♦ eye pain ♦ visual disturbance♦ swelling (face, eyelid, around the eyes)

Rare side effects Allergic reactions, difficulties to swallow, speak or breathe, have been reported rarely when Botulinum Toxin Type A has been used for other uses. Visit your doctor immediately if such signs develop after any Botulinum Toxin treatment.

I agree that after treatment I will avoid alcohol consumption, strenuous physical activity and touching the area for 6 hours and avoid lying down for 4 hours.

I understand that the practice of medicine and surgery is not an exact science and therefore that **no guarantee** can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is improvement, not perfection, and that **there is no guarantee** that the anticipated results will be achieved.

Consent to the treatment detailed in this form:

Name:

Signature:

Date:

TREATMENT RECORD

Date:

Areas Treated:

Product Type:

Lot Number:

Expiry Date:

Notes