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INFORMED CONSENT FOR BOTULINUM (Botox®) TOXIN TREATMENT

Please ensure that you read this document thoroughly. If you have any questions regarding the procedure, please ask Dr Timms and/or the Nurse prior to signing this consent form.

THE TREATMENT

Botulinum toxin (Botox®) is a neurotoxin produced by the bacterium Clostridium A. It causes relaxation of the muscles on areas of the face and neck, which cause wrinkles associated with facial expressions. Facial expression lines or wrinkles will become less noticeable and can essentially disappear and results can last up to 4 months. With repeated treatments, the results may tend to last longer.
Areas most frequently treated are:

- Frown lines, located between the eyes
- Crow's feet (outer areas of the eyes)
- Forehead wrinkles
- Neck bands (platysmal bands)

Botulinum toxin (Botox®) can also assist in treating medical conditions such as Migraines, excessive sweating (hyperhidrosis) and facial palsy.

Treatment is quick, usually taking between 15-20 minutes. It involves a series of injections using a very small, thin needle to deliver the treatment to the areas of concern. You may experience a slight burning sensation while the solution is being injected.

RISKS AND COMPLICATIONS

No procedure is completely risk-free. Although rare, risks include but are not limited to:

- Post treatment discomfort, swelling, redness, and bruising
- Double vision
- A weakened tear duct
- Post treatment bacterial, and/or fungal infection,
- Allergic reaction
- Minor temporary droop of eyelid(s)
- Occasional numbness of the forehead lasting up to 2-3 weeks
- Transient headache Flu-like symptoms may occur.

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

Treatment is not undertaken on pregnant or breastfeeding women, nor is treatment administered to any person with neurologic or significant allergic disorders.

PAYMENT

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

CONSENT:

The procedure has been explained to me. I have read and understand the above and I accept the risks and complications that although rare, may result because of the procedure.
If I have any changes in my medical history, I will notify Mr Timms/nursing and or reception staff prior to any further treatments.
I am not aware that I am pregnant and I am not trying to get pregnant, I am not breastfeeding. I do not have any significant neurologic disease including but not limited to Myasthenia Gravis, Multiple Sclerosis, Lambert Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS), and Parkinson's.

I do not have any allergies to the toxin ingredients, or to human albumin. I hereby voluntarily consent to treatment.

PRESCRIBED/GIVEN TREATMENT:

DATE OF TREATMENT:

PATIENT NAME _____

PATIENT SIGNATURE _____

WITNESS NAME (RN) _____ WITNESS SIGNATURE (RN) _____

DATE / /