PROFHILO®

IBSA

PROFHILO® PATIENT INFORMED CONSENT FORM

I declare to be duly informed about use, indications, contraindications, possible adverse reactions and complications regarding the use of the above-mentioned implants. I certify that the answers to the questions regarding my general health, and previous aesthetic and medical treatments are accurate and correct the best of my knowledge.
I have been given an opportunity to ask questions and have had them fully answered.

Furthermore, I understand that:

- this product is a clear bio-reabsorbable hyaluronic acid gels of non animal origin.
- The duration of the results may vary depending on skin type, treated area, quantity injected and injection techniques.

ADVERSE REACTIONS AND POSSIBLE COMPLICATIONS

I understand that after treatment with the above-mentioned product:

Incidents of inflammatory reactions (erythema, oedema, etc) sometimes associated with itching and pain to the touch may occur. These reactions may persist for 7/10 days. Hardening or nodules may appear at the point of injection.
I was also informed about very rare cases, as described in literature, of discoloration at the injection point, necrosis of glabellar area, abscess, granuloma and hypersensitivity, after hyaluronic acid injections.

If the inflammatory reactions persist more than 7-10 days, I must contact my physician immediately.

I also declare that I am aware of the advice to follow during the post-injection period which I will follow correctly.

Having been properly informed, and having completely understood the advantages of the above mentioned treatment/s and eventual adverse reactions that may occur, I authorise said treatment/s and give my full consent to

Cosmetic Injector _____.

Patient's full name

_____

Please print

Patient's signature & date

_____ ___ / ___ / _____

Cosmetic Injector's full name

_____

Please print

Cosmetic Injector's signature & date

_____ ___ / ___ / _____