Patient Name:

Date:

General Consent for Treatment with Injectables:

- I have discussed my medical history fully with my practitioner, including side effects of complications of my treatment relating to these conditions.
- The use of, and indications for, these products I will be treated with have been explained to me by my practitioner.
- I have discussed realistic expectations with my practitioner.
- I understand that results cannot be guaranteed and that my practitioner will use their best judgement.
- I have had the opportunity to have my questions answered.
- I have discussed aftercare instructions with my practitioner to gain optimal results from my treatment.
- I am aware that the duration of effect of treatment can be shorter or longer than stated in an individual patient.
- I have been specifically informed of the following common injection related reactions: redness, swelling, pain, itching, bruising and tenderness at the treatment site. These reactions are mild to moderate and typically resolve within a few days.
- Repeat treatment will help to maintain the desired correction in the long term.

Patient Initials:

Consent for Treatment with Botulinum Toxin

- I have been advised by my practitioner of the expected outcomes and risks associated with this treatment.
- Potential side effects include feeling of heaviness in the forehead, change in eyebrow position, headache, eyelid swelling, eyelid droop, blurred vision, facial asymmetry, under or over treatment effect, double vision and infection.
- Rare risks include allergy (including anaphylaxis), flu-like symptoms, dry mouth, nausea, muscle twitching, muscle cramps, excessive muscle weakness and swallowing difficulty.
- My practitioner has informed me that the effect of botulinum toxin treatment can last approximately 3 months on average.

Patient Initials:

Consent for Dermal Filler Treatment

- I have been advised by my practitioner of the expected outcomes and risks associated with this treatment.
- We have discussed realistic outcomes regarding the achievable aesthetic result.
- Potential risks include pain, redness, bruising, infection, swelling and firmness at the treatment site, temporary lump, or nodule, under or over treatment effect.
- Rare risks include allergy (including anaphylaxis), persistent lumps or nodules, abscesses and skin discolouration.
- Very rare risks include necrosis, visual disturbance, or blindness.
- My practitioner has informed me that, depending on the product used, area treated, my skin type and the injection technique, the effect of dermal filler treatment can last from 3 - 12 months.
- In the event of an adverse reaction, my practitioner has advised me to contact them directly for further advice.

Patient Initials:

Patient Statement

- I am aware that the record of treatment performed, my personal details, any images taken, and clinical notes will be used both as a medical record of my treatment and as part of my practitioner's confidential portfolio.
- My practitioner has advised me of the product required and the cost of the treatment, which I have already paid, or will pay immediately after treatment including that of any further treatment received.
- I certify that I have read the above information fully and understand the complications that could occur. I have had sufficient time for discussion with my practitioner and agree to treatment today.
- The information that I have given is to the best of my knowledge correct.
- I confirm that my medical questionnaire is up to date and correct at the time of this treatment.
- I believe my request for treatment is for medical reasons. I have expressed my thoughts and feelings to the treating doctor and consent to the treatment for the purpose of restoring and maintaining my health and my psychological well-being.

- I hereby consent to the treatment.

Patient Signature:

Consent to Medical Photography

- I consent to having my photographs taken as part of the medical record of my procedures.
- I consent to having my photographs used in an anonymized form if my practitioner needs to seek advice on treatment options for me from other professionals.

Patient Signature:

- I hereby agree that I have explained the treatment options, the intended effects and potential risks of the treatment listed below to the patient. I have offered an explanatory leaflet and explained where this can be found online.

Clinician Name:

Clinician Signature:

Date:

This consent form will cover treatments for the next 12 months unless the patient withdraws consent or there are changes to the patient's medical history that affect the provision of the treatments covered by this consent.