# BOTULINUM THERAPY CONSENT FORM

*You have the right to be informed about your treatment so that you will make the decision whether or not to undergo the procedure after knowing the risks involved. Disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment. Please initial each section to indicate that you understand each topic.*

**A) PROPOSED TREATMENT**

I have requested that Dr. _______________ attempt to improve my facial expression lines with Botulinum Therapy (BOTOX®, DYSPORT®). A few tiny injections of Botulinum relax overactive muscles and soften the lines of wrinkles that the muscle action has formed. Initials: _____

BOTOX® and DYSPORT® are approved by the FDA to improve the appearance of the vertical lines between the brows. Injections in other areas such as the crow's feet, forehead, and around the mouth to improve the appearance of facial lines have been reported in the literature, but the FDA has not approved those uses. Initials: _____

**B) ANTICIPATED BENEFITS**

Response usually is seen 2-10 days after injection. Less frowning/smile related wrinkling will be possible. Initials: _____

I understand that several sessions may be needed to complete the injection series. I understand that there is a separate charge for any subsequent treatment. Initials: _____

Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point, a repeat treatment will relax the muscle and soften the lines again. Initials: _____

**C) RISKS AND COMPLICATIONS**

Side effects and complications have been minimal. Swelling, redness, and/or bruising may last for several days after the injection. Substances that increases the risk of bruising including Vitamin E, Aspirin, Motrin, Advil, Aleve, Plavix, Coumadin, and other non-steroid anti-inflammatory drugs. If I have taken any of the above within the past 7 days, I have an increased risk of bruising. Initials: _____

Rarely, an adjacent muscle may be weakened for several weeks after an injection which can result in temporary drooping of the eyelids or eyebrows, puffy eyes, or change in the shape of your mouth (if injected). Headaches, respiratory symptoms, difficulty swallowing (if neck injections), numbness, and flu syndrome have been reported in the literature. Other risks have been reported but are less common. Initials: _____

I understand that there may be a higher possibility of side effects if I manipulate or massage the area for at least 3 hours after treatment Initials: _____

**D) LIMITATIONS AND ALTERNATIVES**

Botulinum Therapy is best at treating dynamic facial lines, those caused by facial muscle activity; lines present at rest may or may not improve. Initials: _____

A treatment may be effective for variable lengths of time with subsequent treatments, may not work as well or for as long as expected, or may not work at all. The results of Botulinum therapy are usually noticeable, although the practice of medicine is not an exact science and that no guarantees can be made concerning expected results in my particular case. Initials: _____

Because not all facial wrinkles, creases and folds are caused by muscle activity alone, other alternatives exist for treatment. These include topical treatments (tretinoin, alpha hydroxy acids, vitamin C), injection of fillers, chemical peels, and surgery. Initials: _____

Botulinum should not be used on individuals who are breast feeding, pregnant, or have significant neurological disease such as Eaton-Lambert syndrome or myasthenia gravis. None of the conditions above apply to me. Initials: _____

I have been advised of the risks involved in such treatment, the accepted benefits of such treatment, and alternative treatments including no treatment at all. Initials: _____

**E) PHOTOGRAPHY**

Before and After photographs are an important part of your medical records to help us determine the extent of your improvements. I understand and agree to use of my before and after treatment photographs for use in my patient record and decision making. Initials: _____

I understand and agree to use of my before and after treatment photographs for use in medical education and research. Initials: _____

I will allow use of my pre/post op photos for media relations including advertisements, television, or film. Initials: _____

**F) INFORMED CONSENT**

By signing below, I acknowledge that I have read the above information and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

| 1st Procedure | 2nd Procedure | 3rd Procedure |
|---|---|---|
| Patient Signature | Patient Signature | Patient Signature |
| Staff Signature | Staff Signature | Staff Signature |
| Date | Date | Date |

Sample form courtesy of Margaret Mann, MD