MEDICAL HISTORY TREATMENT RECORD- DERMAL FILLERS

Full Name:

Age: Date of Birth:

Height: Weight:

Address:

City: Post Code:

Telephone: Home: Mobile:

Email:

Allergies:

Smoking history: Non-smoker☐ Ex-smoker☐ Smoker☐ cigarettes/day:

Alcohol consumption (units/week)

Past medical conditions:

Skin care regime details:

What medications are you currently taking?

Are you pregnant or lactating currently?

Previous Operations:

Previous cosmetic procedures:

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: Date:

# INFORMED CONSENT FOR TREATMENT WITH DERMAL FILLERS

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional **prior** to signing the consent form.

# THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately. **Initial \_\_\_\_**

# RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks are essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalisation, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that the risks include but are not limited to: 1) Post treatment discomfort and pain, swelling, redness, bruising, and discoloration of skin; 2) Post treatment infection; 3) Allergic reactions; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma (delayed reaction and lump) formation; 7) Localised skin or tissue loss and necrosis due to blockage of a blood vessel by injected product, and/or sloughing, with scab and/or without scab and 8) asymmetry. **Initial \_\_\_\_**

# PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. **Initial \_\_\_\_**

# ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial \_\_\_\_**

# PAYMENT

I understand that this is an "elective” procedure and that payment is my responsibility and is expected before receiving treatment. **Initial \_\_\_\_**

# RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial \_\_\_\_**

# PUBLICITY MATERIALS

I authorise the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial \_\_\_\_**

# RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 12 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear sufficiently, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post- treatment instructions. **Initial \_\_\_\_**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. If I am being treated as a cosmetic model and not a private client, I understand that my treatment will be undertaken by learning delegates under the direct supervision of aesthetic practitioners. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

# The Dermal Filler treatment I am receiving is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My **questions** have been answered satisfactorily. I accept the risks and complications of the procedure. I certify that if I have any changes occurring in my medical history, I will notify my practitioner.

Patient Signature: Date:

# For the treating professional: I am the supervising healthcare professional. The patient has had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact the practice should they have any questions or concerns after treatment.

Name

Signature:

Date:

I am satisfied with the results of the treatment (or re-treatment/ correction if applicable) that I have received today. I have had the opportunity to ask questions and review my results personally through photos taken and mirror reflection.

Patient Signature: Date: