INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION

(botulinum toxin type-A)

FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES

Please initial after each statement and sign at the bottom.

Botox is the botulinum toxin and works by paralyzing nerves and muscles.

1. I, _____, consent to and authorize Dr. Roberts to perform a treatment of facial wrinkles with Botox. _____**(initial)**
2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. _____**(initial)**
3. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____**(initial)**
4. I am fully aware of the risks of complications of injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____**(initial)**

The known complications could include:

- Redness, swelling/edema, itching, bruising, pain or pressure lasting more than one week
- Nodules or induration at the site of injection
- Discoloration of the injection site
- Minimal effect requiring additional doses. Or poor effect, or no effect at all.
- Allergic reactions
- The effects of Botox are apparent from 4 to 14 days after treatment
- The effects usually last 3-5 months. Periodic retreatment will be necessary to maintain the effects of Botox
- Facial asymmetry
- Paralysis leading to droopy eyelid and double vision
- Some patients may experience weakness, flu-like symptoms, or headache
- Some patients may develop antibodies to Botox
- Botox may migrate to areas away from site of injection
- Botox may cause difficulty breathing or swallowing
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5. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy, or allergy to albumin. I am not pregnant, am not breast-feeding, and I have no known allergy to Botox. _____**(initial)**
6. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. _____**(initial)**
7. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. _____**(initial)**
8. No guarantee, warranty or assurance has been made as to the treatment results
9. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including:
    - No laying down or reclining for four hours after injection
    - No scratching or rubbing the injected area
    - No bending forward for four hours
    - Make up should be avoided for one to two hours after injection

Patient Name (please print) _____

Signature_____ Date _____