KAT & CO
AESTHETICS

Consent for Dermal Fillers/Botulinum Toxin Type A (V. 08/15)

The use of and indications of the products with which I will be treated with have been explained to me by my practitioner and I have had the opportunity to have all questions answered to my satisfaction. I have been specifically informed of the following: after the treatment some common injection related reactions might occur. These reactions include redness, swelling, pain, itching, bruising and tenderness at the treatment site. These are generally described as mild to moderate and typically resolve spontaneously a few days after treatment.
Your initials to indicate that you have read and understood this information_____

Dermal Fillers

Other types of reaction are rare, but approximately one in every 10,000 patients treated with a dermal filler has experienced localised allergic reactions after one or more injection treatments. These have usually consisted of swelling and firmness at the treatment site, sometimes affecting the surrounding tissues. Redness, tenderness and rarely acne-like formations have also been reported. These reactions have either started a few days after injection or after a delay of several weeks. They have been described as mild to moderate and self limiting with an average duration of two weeks. In rare instances such reactions or lump formations like granulomas have persisted for a number of months.
Your initials to indicate that you have read and understood this information_____

On very rare occasions (less than 15,000) prolonged firmness, abscess formation or greyish discolouration at the implant site has occurred. These reactions can develop weeks to months following the injections and may persist for several months but normally resolve in time. Even more rarely, the formation of a scab and sloughing (shedding) of tissue at the treatment site has been noted, which could result in a shallow scar. A report published in 2012 discussed 32 reported incidents of blindness following dermal filler treatment in areas including the glabellar frown lines, under eye area, and temple. In a separate study published in 2013, of the 6 visual disturbance cases reported, 3 were following glabellar frown line treatment with dermal filler.
Your initials to indicate that you have read and understood this information_____

The chances of accidental injection into a blood vessel are very small. However, if it does happen, the complications can be serious and may be permanent. These complications, which have been reported for facial injections, can include vision abnormalities, blindness, stroke, temporary scabs or permanent scarring of the skin. If you experience changes in your vision, signs of a stroke (such as sudden difficulty speaking, numbness or weakness, difficulty walking, face drooping, severe headache, dizziness or confusion), white appearance of the skin, or unusual pain during or shortly after treatment, you must notify your health care practitioner immediately.
Your initials to indicate that you have read and understood this information_____

My practitioner has also informed me that depending on the product used, area treated, skin type and the injection technique, the effect of the treatment can last 6-12 months. (Lip enhancement will last approximately 6 months.) In some cases the duration may be shorter or longer. Follow-up treatment will help maintain the desired correction. My practitioner has advised me of the amount of product required and the cost of the treatment which I agree to pay in full at the time of treatment.
Your initials to indicate that you have read and understood this information_____

Wrinkle relaxant

For muscle relaxation injections with botulinum toxin Type A: I have been advised by my practitioner of the expected outcomes and risks associated with this treatment. In particular, we have discussed realistic outcomes regarding the onset of action and the duration of effect, together with potential side effects including those related to the site of injection and the generalised common and uncommon side effects including headaches, muscle activity disorders (raised eyebrows), feeling of heaviness in the upper part of the face, accumulation pf fluid in the eyelids (eyelid oedema), drooping eyelids (eyelid ptosis),inflammation of the eyelid, eye pain, blurred vision, fainting, noises in the ears (tinnitus), nausea, dizziness, muscle twitching, muscle cramps, localised muscle weakness in the face (drooping eyebrow), dry mouth, flu symptoms, influenza, bronchitis, inflammation of the nose and throat, infection and in rare cases, excessive muscle weakness and difficulties in swallowing. In the event of an adverse event my practitioner has advised me to seek medical care immediately.
Your initials to indicate that you have read and understood this information_____

Have you had any change in your medical history including any medical problems, procedures, allergies/anaphylaxis or episodes of cold sores? Yes☐ No☐ If yes, please provide details: _____

I confirm that my request for treatment is for medical reasons and/or restoring and maintaining health and psychological wellbeing. This includes the purpose of improving confidence/mood, concerns regarding facial ageing and interactions with others, asymmetry or concerns/anxiety regarding my appearance? Yes☐ No☐

The information that I have given is to the best of my knowledge correct ☐

I have not knowingly withheld any medical or surgical information ☐

I agree to inform my practitioner of any changes to me medication or health in the future. ☐

I have read the above information fully and understand the possible complications that could occur. I have discussed these with my practitioner and agree to treatment ☐

I have been provided with sufficient information about the treatment in order to make an informed decision. ☐

I have been given the opportunity to ask all remaining questions I may have about the treatment. ☐

I have been given time to consider the treatment. ☐

I consent to the use of topical anaesthetic cream: Yes☐ No☐

I consent to the use of Lidocaine (injected anaesthetic) products during the treatment: Yes☐ No☐

I consent to the use of the anonymised before and after photos for educational and promotional purposes. Yes☐ No☐

Patient Name [PatientFirstname] [PatientLastname]

Patient ID Number [Patientno]

Patient Signature_____ **Date** [TodayShort]

Practitioner's notes

The patient has read the Consent to treatment fully and we have discussed the possible complications that could occur, The patient has agreed to the treatment. ✓☐

I have talked through the information to the patient in the following information leaflets:

Botulinum Toxin (pre-treatment, treatment and post-treatment) ☐✓

Dermal fillers (pre-treatment, treatment and post-treatment) ☐✓

Radiesse Brochure ☑

Belotero Brochure ☑

The patient requires the procedure for medical reasons and/or restoring and maintaining health and psychological wellbeing:

Yes☐ No☐ Comments:

Practitioner name_____**C C Kat**_____

Practitioner Signature_____ **Date** [TodayShort]