Botox and Dermal Filler Consent

Informed consent. The dermatologist fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

DERMATOLOGIST NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

TREATMENT

AREAS

DATE

PRODUCT AND BATCH

UNITS / ML

These are prescription treatments given by a qualified doctor. Botox relaxes muscles for about 3 to 4 months; fillers add volume for 6 to 18 months. Results vary and a top-up may be needed.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Bruising, swelling and tenderness
- Asymmetry or an unwanted look, which may need correction
- Drooping eyelid or brow after botox (temporary)
- Lumps or infection after filler
- Filler blocking a blood vessel, causing skin damage or, very rarely, vision loss

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Skincare, peels or laser treatments
- No treatment

Your health

Are you pregnant or breastfeeding?

○ No ○ Yes

Do you have a neuromuscular disorder?

○ No ○ Yes

Have you had filler or permanent implants in the same area?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

☐ I agree to before and after photos for my record. They will not be shown publicly without separate written consent.

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The dermatologist has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Dermatologist

SIGNATURE

PRINTED NAME

DATE