Consent to Botulinum Toxin Treatment

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. 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 healthcare professional prior to signing the consent form.

I read and write in English. **Initial** _____

The Treatment
Botulinum toxin is a neurotoxin produced by the bacterium clostridium A. Botulinum toxin can relax the muscles in the areas of the face and neck which cause wrinkles associated with facial expressions. Treatment with Botulinum toxin can cause facial expression lines or wrinkles to be less noticeable or softer. Botulinum toxin is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) lip lines (smoker's lines), e) head and neck muscles. The procedure takes about 15-20 minutes. With repeated treatments, the results may tend to last longer. **Initial** _____

Risks and Complications
It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, and bruising 2) Double vision 3) A weakened tear duct 4) Post treatment bacterial, viral, and/or fungal infection requiring further treatment 5) Allergic reaction 6) Temporary droop of eyelid(s), this usually lasts 2-3 weeks. 7) Occasional numbness of the forehead lasting up to 2-3 weeks 8) Transient headache 9) flu-like symptoms may occur. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. **Initial** _____

Photographs
I authorize the taking of clinical photographs/videos and their use for scientific and marketing purposes both in publications and presentations. **Initial** _____

Pregnancy, Allergies & Neurological diseases
I am not aware that I am pregnant, nor am I trying to get pregnant, and I am not lactating (nursing). I do not have any significant neurological diseases including but not limited to myasthenia graves, multiple sclerosis, lambert-Eaton syndrome, Amyotrophic lateral sclerosis (ALS), or Parkinson's. Additionally, I do not have any allergies to the toxin ingredients or to human albumin. **Initial** ___

Right to Discontinue Treatment
I understand that I have the right to discontinue treatment at any time. **Initial** _____

Payment
I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. I understand adjustments requiring more product incur a charge. **Initial _____**

Alternative Procedures
Alternatives to the procedures have been fully explained to me. **Initial _____**

Results
I am aware that the results appear in 10-14 days and usually lasts 3-4 months, but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re- treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area (s) of the injections for the 4 hours post-injection period. I understand that I will not rub or massage the injected area for a minimum of 24 hours. I will also avoid exercise, extreme cold or heat (i.e. saunas, hot tubs).
Initial _____

The procedure has been explained to me. I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism (to grind or clench teeth) and types of orofacial pain including headaches and migraines. 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 understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician.

I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

_____

Patient Name (Print) **Patient Signature** **Date**

I discussed the above risks, benefits and alternative treatments, including no treatment, with the patient. The patient had an opportunity to have all questions answers and has voiced concerns, if any. Post-treatment instructions will be given and explained to patient. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Injector Name (Print) **Injector Signature** **Date**

Consent to Dermal Filler treatment

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. 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 healthcare professional prior to signing the consent form.

I read and write in English. **Initial** _____

The Treatment
Treatment with dermal fillers 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. The results can often be seen immediately. Client may experience a slight burning sensation during injections. The procedure itself takes about 20-30 minutes. Results last approximately 6-12 months. **Initial** _____

Risks and complications
No procedure is completely risk-free. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. The following risks may occur, but are not limited to:

1. Post treatment discomfort, swelling, redness, bruising, and discoloration. **Initial** _____

2. Infection: Bacterial, viral or fungal infections can occur post procedure. Infections can progress into abscesses just under the skin. Injections into the lip area could trigger a recurrence of cold sores (Herpes simplex). These problems may resolve over time, but medical intervention may be required in some cases, and long-term effects may persist in rare cases. **Initial** _____

3. Reactions: Reactions rarely occur but can include an immediate reaction causing swelling, and very rarely life-threatening anaphylaxis. Delayed reactions localized to the skin can cause nodules, lumps, bumps or granulomas; and very rarely sterile abscesses. These may occur soon after the procedure or months later. The chance of delayed reaction increases if you have active autoimmune disease and/or an active viral or bacterial infection elsewhere. **Initial** _____

4. Lumps, Bumps, Swelling: Unwanted visual effects may cause dissatisfaction or distress, and include an increase in asymmetry, swelling, lumps, bumps, and/or puffiness. These non-inflamed filler side effects are temporary and treatable with full resolution likely. **Initial** _____

5. Skin Changes: Procedures are rarely associated with pigment changes, the formation of thread veins or new capillaries, enhancement of Fordyce spots on lips and other blemishes. **Initial** _____

6. Blood Vessel Blockage: Immediately if you suspect blood vessel occlusion is vital to prevent scarring. There are extremely rare cases in which blood supply to the eye or parts of the brain being affected causing blindness and stroke. Seeking help immediately if you suspect blood vessel occlusion is vital to preventing scarring. Your nurse injector will teach you how to look out for signs and symptoms. **Initial** _____

Photographs
I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. **Initial _____**

Pregnancy + Allergies
I am not pregnant, or have significant medical diseases or have any severe allergies. **Initial _____**

Dissatisfaction
I understand that with all treatments the precise degree of improvement cannot be guaranteed. The outcome's subjective nature also means dissatisfaction is a possible outcome regardless effectiveness of treatment. I understand that the effect of all treatments may gradually wear off, additional treatments may be necessary to acquire desired effect, and further charges will apply if more product is required. 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/ lifestyle 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. **Initial ___**

Payment and Follow Up
I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. I understand adjustments at a follow-up visit, requiring more product will incur a charge. **Initial _____**

By signing this form, you agree that you have read this form carefully and understand the side effects, risk and uncertainty of the outcome and decided the treatment is still in your best interests. You have discussed all the details of the treatment plan, past treatments and your medical history with your clinician and shared all the information your clinician may need to plan treatment. 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 certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

_____

Patient Name (Print) **Patient Signature** **Date**

I discussed the above risks, benefits and alternative treatments, including no treatment, with the patient. The patient had an opportunity to have all questions answers and has voiced concerns, if any. Post-treatment instructions will be given and explained to patient.

_____

Injector Name (Print) **Injector Signature** **Date**

The Lotus and The Ladle
Medical Spa and Wellness Center

COVID 19 SCREENING

Visitor Name _____ DATE _____

Contact Number: _____ Email: _____

	YES	NO
1. Are you experiencing any of the following symptoms:		
a. Fever of 38 C or higher		
b. Cough		
c. Difficulty Breathing or Shortness of Breath		
d. Malaise (severe fatigue or feeling generally unwell)		
2. In the last 14 days have you:		
a. Travelled to/from or through • China • Hong Kong • Iran •Italy • Japan YES NO • Singapore • South Korea • France • Spain • Germany		
b. Been in close contact with someone who has a confirmed or probable case of COVID-19		
c. Been in close contact with a person with an acute respiratory illness who has been to the above countries within 14 days prior to their illness onset?		

PRINT NAME **SIGNATURE.** **DATE**

Medical History

Name:_____ DOB: _____ Age:_____
Telephone:_____ Email: _____
Address:_____ Instagram:_____

MEDICAL HISTORY

Please list medications: (including prescription, oral, over the counter, topical, supplement or herbal)

_____

_____

Are you pregnant or lactating? (circle) Yes OR NO

Are you on any antibiotics? _____

Do you have any of the following medical conditions? (Please mark YES or NO to all)

PLEASE CHECK ALL THAT APPLY	YES	NO		YES	NO
Cancer			Diabetes		
High Blood Pressure			Herpes		
Arthritis			Frequent cold sores		
HIV/AIDS			Keloid scarring		
Skin Disease			Skin Lesions		
Seizure Disorder			Hepatitis		
Hormone Imbalance			Thyroid Imbalance		
Blood Clotting Abnormalities.			Any active infection		
Heart Conditions.			NEUROLOGICAL DISEASES:		
Parkinson's.			Myasthenia Graves		
Multiple Sclerosis (MS).			Lambert-Eaton Syndrome		
Amyotrophic Lateral Sclerosis (ALS)					

Any known allergies or allergic reactions
to the following? (check the box)

☐Animal Protein ☐Aspirin ☐Hydrocortisone ☐Lidocaine (Anesthetic)
☐Latex. ☐Eggs ☐Bee Sting ☐Hydroquinone or skin ☐bleaching agents
Others allergies: _____

Have you taken any Aspirin, Ibuprofen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, and Alcoholic Beverages in the last ten days? (circle) YES or NO If yes, what? _____

FACIAL HISTORY

Have you ever had Botox or dermal fillers? (circle) YES or NO
If yes, when were you last treated: _____
Product name: _____
Any complications? (circle) YES or NO
If yes, please specify: _____

FACIAL INJURY TRAUMA HISTORY

1) Any history of facial surgery? (circle) YES or NO
Describe: _____

2) Any history of trauma to the head or face? (circle) YES or NO
Describe: _____

Any TMJ problems? (circle) Pain Clenching Grinding

Other medical conditions: _____

Previous Hospitalization/ Operations? _____

Any scheduled dental cleaning or procedures in the next 2 weeks? (circle) YES or NO

Are you leaving the city in the next two weeks? (circle) YES or NO

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 clinic as soon as possible. I have read and understood the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____

Patient Name (Print) **Patient Signature** **Date**

I am the treating nurse/healthcare professional. I have reviewed this medical history with the patient and medical director.

_____

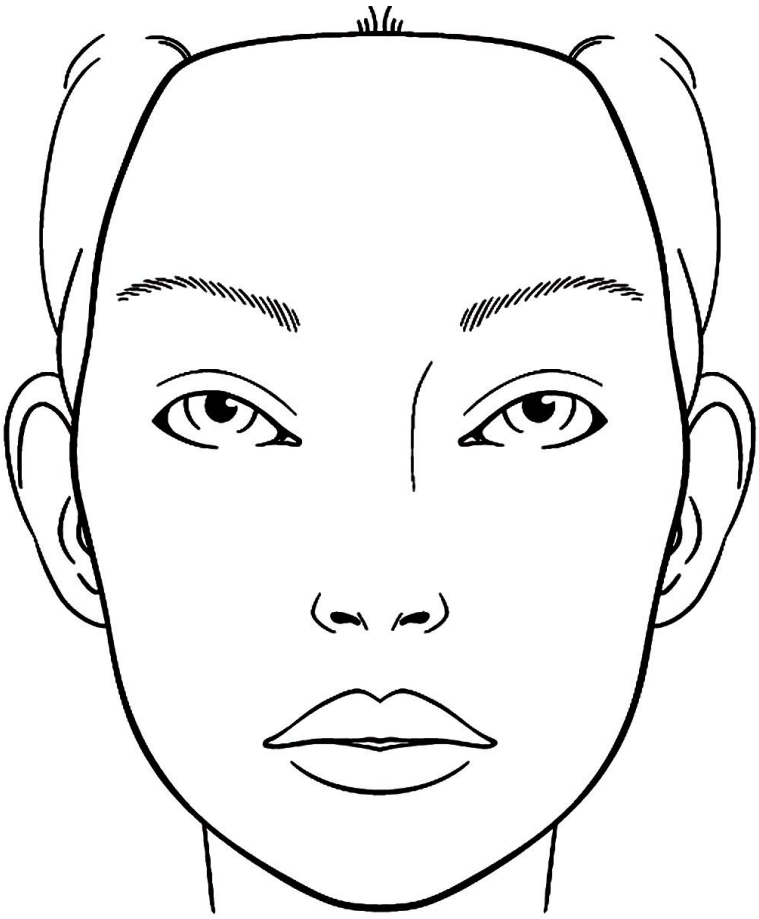
Injector Name (Print) **Injector Signature** **Date**

The Lotus and The Ladle
Medical Spa and Wellness Center

To be filled out by Nurse Injector

Patient Name: _____ **Injector Name:** _____

Use face template to indicate treatment areas.



Dermal filler: ☐
Place product sticker(s) here:

Botox: ☐
Lot #: _____
Expiry: _____

Consult completed by Medical Director:

Jane Smith, MD ☐

Progress Note

HYALURONIDASE CONSENT FORM

The Lotus and The Ladle
Medical Spa and Wellness Center

Name: _____ **DOB:**_____
Telephone:_____ **Email:**_____

This is an informed consent document that has been prepared to help inform you concerning hyaluronidase injections and the risks involved.

Treatment

Hyaluronidase is a prescription only formulation, licensed and commonly used to boost absorption or dispersal of drugs injected into the skin and has an off license use in aesthetic medicine. Hyaluronic Acid (HA) fillers are sterile gels consisting of non-animal stabilised hyaluronic acid for injection into the skin to correct facial lines, wrinkles and folds, for lip enhancement and for shaping facial contours. Hyaluronidase is an enzyme which breaks down hyaluronic acid. Hyaluronic acid is the component of dermal fillers, but is also naturally occurring in the skin and soft tissues. Occasionally dermal fillers need to be dissolved when the treatment outcome is unacceptable, when an adverse reaction to the implant has occurred, or there is a possibility of vascular occlusion and/or impending necrosis (tissue death) which could lead to the compromise of healthy tissue. **Initial** _____

General Information and Risks

Every procedure involves a certain amount of risk, and it is important that you understand that risks involved. Hyaluronidase is an enzyme which breaks down hyaluronic acid fillers, but it can also break down naturally occurring hyaluronic acid present in the body, the results can be unpredictable and the effect dramatic. There will be loss of volume and there can be some skin laxity which in itself may not provide a good aesthetic result. Although some of the effects can be immediate, it can take up to 14 days for the final results to be seen and the treatment may need to be repeated. **Initial** _____

Allergic Reactions

Administration can result in anaphylaxis, a severe allergic reaction which in itself is life threatening and requires immediate medical attention. Allergic reactions occur at a frequency of 0.05% - 0.69%. **Initial** _____

Hyaluronidase has an off-license use in aesthetic medicine and except in the case of emergency administration requires the patient to undergo a skin patch test at least twenty minutes prior to the procedure being undertaken. The skin patch test is carried out by injecting hyaluronidase into the subcutaneous tissue of the forearm and observed for signs of reaction (i.e. hives or wheals). **Initial** _____

****If a positive patch test result is observed, treatment with hyaluronidase cannot be carried out. Erythema or redness and slight vasodilation may be expected. ****

HYALURONIDASE CONSENT FORM

IF IN AGREEMENT, PLEASE INITIAL THE FOLLOWING:

I understand that there will be loss of volume and there can be some skin laxity which in itself may not provide a good aesthetic result. **Initial _____**

Although some of the effects can be immediate, I understand that it can take up to 14 days for the final results to be seen and the treatment may need to be repeated. **Initial_____**

I understand that hyaluronidase administration can result in anaphylaxis and have been given full counselling and the opportunity to discuss the treatment with hyaluronidase, conservative treatment options or leaving the dermal filler to break down naturally which may take several months dependent on the type of filler used and the area treated.
Initial _____

The use of and the indications for the administration of hyaluronidase have been explained to me by my practitioner and I have had the opportunity to have all questions answered to my satisfaction. **Initial _____**

After the treatment some other common injection-related reactions might occur. These reactions include redness, swelling, pain, itching, bruising and tenderness at the injection site. They have generally been described as mild to moderate and typically resolve spontaneously a few days after injection. Bruising may occasionally be more significant.
Initial _____

I acknowledge that I will have to remain at the clinic for thirty minutes after the procedure so that I can be observed by the medical staff and that I will need to return to the clinic 2-3 weeks after treatment to assess if further hyaluronidase is to be administered. **Initial_____**

I hereby voluntarily consent to treatment with Hyaluronidase injected into the recommended treatment area and the procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

_____

Patient Name (Print) **Patient Signature** **Date**

I discussed the above risks, benefits and alternative treatments, including no treatment, with the patient. The patient had an opportunity to have all questions answers and has voiced concerns, if any.

_____

Injector Name (Print) **Injector Signature** **Date**