



CONSENT FORM

4600155198WJ 1954-Nov-19

Patient Name : _____

Dr. Ramesh Seegobin

Please ensure that you have had all of your questions answered before signing!

BOTOX CONSENT

I am aware that when a small amount of purified botulinum toxin (BOTOX) is injected into a muscle it causes weakness of that muscle. T results start to appear in 3-4 days (full results in two weeks) and usually lasts four months but can be shorter or longer To maximize the result: should contract the injected muscles as frequently as possible until bedtime on the day of the injection.

I must stay in the erect posture an must not touch or manually manipulate the injection site with my fingers for a three hour post-injection period. I will not be able to move t treated muscle(s) while the medication is effective, but understand tiis will reverse itself after a period of four to six months at which time i treatment is appropriate.

Risks and Complications

I understand that Botox treatment can cause temporary droop of one eyelid in approximately 1-2% of injections. This usually lasts two to thr weeks. but can last four to six months. Recognized side effects inclede transient headache (for which Tylenol or Advil will help), bruising a transient numbness or discomfort of the forehead. When the lower facial and neck area is injected with Botox, there is a risk of experience transient difficulty with speaking or laughing.

I understand that in some individuals. Botox cosmetic treatments are not effective or do not last as long as four months.

Photographs

I authorize the taking of clinical photographs and their use for scientific purposes both in the publications and presentations. I understand r identity will be protected.

Pregnancy and Neurological Disease

I am NOT pregnant, nor do I have any significant neurological disease (including muscular sclerosis).

I have read the above and understand it. My questions have been answered satisfactorily by the doctor and nurses. I accept the risks at complications of the procedure.

Dated : _____

Dated : _____

Dated : _____

Signature (Patient or legal guardian)

Signature (Patient or legal guardian)

Signature (Patient or legal guardian)

FILLERS CONSENT

The filler products used at Martin's Vein and Medical Aesthetics clinic are sterile gels consisting of non-animal stabilized hyaluronic acid f injection into the skin. Their purpose is to correct facial lines, wrinkles and folds, enhance the lips and/or shape facial contours.

Risks and Complications

The use of and indications for the filler products have been explained b me and 1 have had the opportunity to have all questions answered to r satisfaction. I have been specifically informed of the following: after trie injection some common injection-related reactions might occur, sly as swelling, redness, pain, itching. infection, discoloration and tenderness at the implant site They typically resolve spontaneously.

Other types of reactions are very rare, but 1 in 2000 treated patients have experienced localized reaction thought to be of a hypersensitiv (allergic) nature. These have usually consisted of swelling at the implant site, sometimes affecting the surrounding tissues. RedneE tenderness and rarely acne-like formations have also been reported. These reactions have either started a few days after injection or after delay of two to four weeks.

Expectations

I have been informed that depending on the area treated, skin type and the injection technique the effect of treatment with filler products oi last six to twelve months, but in some cases the duration of the effect can be shorter or even longer. Touch-up and follow-up treatment hell sustain the desired degree of correction.

Photographs

I authorize the taking of clinical photographs and their use for scientific purposes both in the publications and presentations. I understand n identity will be protected

Pregnancy and Negrotggigal Disease

I am NOT pregnant, nor do I have any significant neurological disease (including muscular sclerosis).

I have read the above and understand it. My questions have been answered satisfactorily by the doctor and nurses. I accept the risks ar complications of the procedure.

Dated : _____

Dated : _____

Dated : _____

Signature (Patient or legal guardian)

Signature (Patient or legal guardian)

Signature (Patient or legal guardian)

Patient Name : _____

	AREA 1	AREA 2	AREA 3	AREA 4
Treatment Date				
Dilution (ml)				
Units/0.1 ml				

Location				
Lot Number				
Expiration Date				

Total Units/Site				
Site A				
Site B				
Site C				
Site D				
Total Units Used				

Patient History :



Notes :