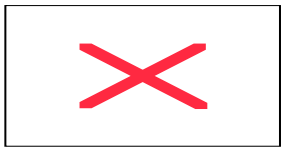

RESTYLANE ® INJECTABLE GEL
CONSENT FORM

Brief Medical History

Name_____**Phone**_____**Age**_____**Ht**_____**Wt**_____
Address_____**City/State**_____**Zip**_____
MEDICATIONS:_____
ALLERGIES: _____ **Women: Are you Pregnant or Lactating?** _____
Physician's Name_____

Circle any of the following history you have or have had in the past:

History of Anaphylaxis **Multiple Severe Allergies** **Facial Acne** **Facial Rashes** **Hives** **Herpes**
Active Inflammatory process **Infection (at proposed injection sites)** **Autoimmune Disease**
Immunosuppressive Therapy **Any other Medical Disease**

Explain:_____

Previous Hospitalizations/Operations:_____

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 office as soon as possible. I have read and understand 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 Signature_____**Date**_____

RESTYLANE ® ADMINISTRATION CONSENT

Restylane is a gel of hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic buffer at PH=7 and concentration of 20 mg/ml. areas most frequently treated are: nasolabial folds, oral commissures, lips, and Glabellar. Client may experience a slight burning sensation during injections. The procedure takes about 20-30 minutes. Results last approximately six months.

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) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction

PHOTOGRAPHS

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

PREGNANCY, ALLERGIES

I am not aware that I am pregnant, have any significant Medical diseases, or have any severe allergies.

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility.

I hereby voluntarily consent to treatment with Restylane® injection for the condition known as: Facial Static Wrinkles. 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 Signature **Date** **Witness Signature** **Date**