Botulinum Toxin Patient Protection Consent Form

Today's Date _____

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone :( )_____

E-mail Address: _____ Cell Phone:( )_____

Choice of contact: ☐Text ☐E-mail ☐Phone call ☐Any Other_____

Sex: ☐Male ☐Female Date of Birth: _____ Age: _____

☐Single ☐Married ☐Domestic Partners ☐Separated ☐Divorced ☐Widowed

Name of Spouse: _____

Emergency Contact: _____ Phone: ( )_____

Relationship: _____

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who may we thank for referring you? _____

Medical History

Physician's Name: _____ Physicians Phone: ( )_____

Date of Last Physical Exam: _____

Have you ever had any of the following? (check boxes that apply)

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Artificial Heart Valve
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bisphosphonates
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problem
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Gastric Ulcers
- ☐ Glaucoma
- ☐ Headaches/ Migraines
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ HIV/ AIDS
- ☐ Immune Disorder
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease/ Jaundice
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tuberculosis

Surgeries: _____

Allergies

Latex	Local Anesthetic	Aspirin
Codeine	Penicillin	Sulfa Drugs
Egg-protein	Botox	

Other: _____

Medications

List the medications you are currently taking:

_____

_____

_____

Women Only:

Are you pregnant? ☐ Y ☐ N If yes, # of weeks _____

Are you Nursing? ☐ Y☐

INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

You have the right to be informed about your skin condition and treatment so that you can make the decision about whether or not to undergo the procedure after knowing the risks and benefits involved. This information is not meant to alarm you, but to better inform you so that you may give or withhold your consent for the treatment of your cosmetic condition as well as help you formulate additional questions which may not have been covered in consultation. You have the right to discontinue treatment at any time. The alternative option to treatment is to withhold treatment. At this time, withholding treatment is the only medically proven alternative option.

THE TREATMENT

Botulinum toxin (Botox® and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck, which causes wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. 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) radial lip lines (smokers lines); e) head and neck muscles. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all.

The injection of Botulinum Toxin for this purpose has been explained to me and my questions regarding such treatment, its alternatives, its complications and risks have been answered by the doctor or her representative. The information given to me has been in clear terms and I understand the risks and complications of the treatments. I understand that Botulinum Toxin is approved only for the glabellar, frontalis and orbicularis oculi regions and that injection into any area other than those is considered off-label use. The treatment plan is to inject a small amount of Botox®, a purified neurotoxin produced by the Clostridium bacteria, into a targeted facial muscle to intentionally produce weakness or temporary paralysis of that muscle. This results in the relaxation of the muscle and improvement of the lines and wrinkles that the targeted muscle action produced or improved contour of the face. The response is usually seen in 2-6 days after injection. It is common for the muscle's action along with its associated wrinkles to returns in 3 to 6 months. Repeat injections are necessary to maintain its effects. I understand that lines and wrinkles present at rest may not improve with treatment with Botox® alone, since Botox® is designed to treat lines caused by facial muscle action. Although results are frequently dramatic, as high as 10% of patients may not respond to these treatments for unknown reasons. I understand that the practice of medicine and surgery is not an exact science and that no guarantees can be or have been made concerning expected results in my case. Repeated sessions may be necessary in certain muscle groups to obtain the desired results. A charge will be made for each treatment session. Larger muscle groups require more Botox® and larger charges will be made according to the number of units of Botox®. I may plan for multiple treatment sessions in the future, which are completely at my discretion as to the number, extent or amount.

<u>After treatment</u>: I understand that fewer facial expressions will be possible after my injections with Botox®. I understand that I should stay upright and not lie down for 4 hours after injection. I will not massage the injected sites for at least 4 hours. I will contract the injected muscle for 1 hour after injection.

RISKS AND COMPLICATIONS
You may experience minor side effects including: headache, slight bruising at the injections site, localized numbness, rash, flu symptoms, lid/brow ptosis and temporary loss of nearby muscle function. These are temporary and usually reside within a few days to weeks. In extremely rare cases (<1%), further medical attention and hospitalization may be required.

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE
I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to Myasthenis Gravis, Multiple Sclerosis, Lambert-Eaton syndrome, Amyotrophic Lateral Sclerosis (ALS), and Parkinson's. I do not have any allergies to the toxin ingredients or to human albumin.

TRAINING COURSE
I understand that I am participating in a teaching course and can elect to discontinue treatment at any time. I also understand that I have volunteered to be a model patient in a training course and the doctor/healthcare professional who will be treating me has had limited experience with the method of treatment.

I hereby indemnify Tracy S. Blessing, D.M.D. and the University of Florida from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative question or concerns to the treating clinician.

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

Patient Name (Print) Patient Signature Date