BOTULINUM INJECTION (BOTOX/DYSPORT/XEOMIN) CONSENT FORM

Name:

Date of birth:

Address:

Phone number:

Email:

Please read this consent form thoroughly.

Please answer all questions.

If you have any uncertainty regarding questions, please discuss with your doctor.

I _____, hereby consent to undergo botulinum toxin injection by _____. I understand that Botulinum injections are performed using a fine needle to inject small amounts of botulinum toxin into specific muscles.

Purpose of Treatment: Botulinum Toxin Type A is a prescription medicine that is injected into muscles and used to temporarily improve the look of both moderate to severe frown lines between the eyebrows (glabellar lines), crow's feet lines, and forehead lines in adults.

Treatment Plan: -

- The procedure typically takes about 10-30 minutes.

- Results may begin to appear within 24 to 48 hours but may take up to 2 weeks to take full effect. Results usually last 3-4 months.

Please answer the following questions.	Yes	No
1. Do you currently have an infection in the area you would like to treat?	Y	N
2. Do you have known allergies or sensitivity to Botulinum toxin type A ?	Y	N
3. Do you currently have open wound or cuts in the area you would like to treat?	Y	N

4. Do you have Diabetes?	Y	N
5. Are you on any treatment for your heart or high blood pressure?	Y	N
6. Are you currently pregnant or breastfeeding?	Y	N
7. Have you had Botulinum toxin type A before?	Y	N
8. If yes, have you previously had problems with injections of Botulinum toxin type A?	Y	N
9. Do you have suffer from seizures?	Y	N
10. Do you suffer from any bleeding disorder?	Y	N
11. Are you currently using blood thinners including Aspirin?	Y	N
12. Do you or have you had difficulties with swallowing?	Y	N
13. Do you suffer with muscle weakness or have a muscle disorder?	Y	N
14. Are you due to have surgery?	Y	N
15. Are you using any medication? Please list them below.	Y	N

Risks and Side Effects:		
I understand that while Botox is generally safe, there are potential risks and side effects, including but not limited to:	Y	N
Pain, swelling, or bruising at the injection site.	Y	N
Headache or flu-like symptoms	Y	N
Allergic reactions (rash, itching, asthma symptoms)	Y	N
Drooping eyelid or eyebrow		
Crooked smile or drooling		
Eye dryness or excessive tearing	Y	Y

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Pre-Procedure Care

-Inform your healthcare provider of any medical conditions, including muscle or nerve conditions such as ALS, myasthenia gravis, or Lambert-Eaton syndrome.

- Discuss any medications you are taking, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

- Avoid alcohol for at least 24 hours before the procedure.

- Avoid taking aspirin or other blood-thinning medications several days before the procedure to reduce the risk of bruising.

Post-Treatment Care

I understand the importance of following post-treatment care instructions,

- Do not rub or massage the treated areas for 24 hours to avoid spreading the toxin.

- Avoid strenuous exercise, exposure to extensive sun or heat, and alcoholic beverages for 24 hours post-treatment.

- Follow any additional post-treatment instructions provided by your healthcare provider.

Financial Responsibility

I understand that I am financially responsible for the botulinum toxin treatment sessions as discussed with the clinic.

Patient Consent

I have read and understand the information provided in this consent form. I have had the opportunity to ask questions and all my queries have been answered to my satisfaction.

By signing below, I consent to undergo botulinum toxin treatment.

I have read and understand the above information about Botox/ Xeomin/Dysport injections. I have discussed the procedure with my healthcare provider and have had all my questions answered to my satisfaction. I understand the risks and benefits associated with Botox/ Xeomin/Dysport injections and agree to proceed with the treatment.

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By signing this form, I consent to receive Botox/ Xeomin/Dysport injections from Dr. BB Crook at Arcabee Aesthetics.

Patient Signature: _____ Date: _____

Healthcare Provider Signature:_____ Date:_____