REVITALIZE MEDICAL SPA
SKINCARE • INJECTIONS • LASER

# BOTOX (BOTULINUM TOXIN) TREATMENT CONSENT FORM

**BRIEF MEDICAL HISTORY**

Name:_____ Age:_____ Height:_____ Weight: _____

Telephone: Home:_____ Cell:_____

Address:_____

City/State:_____ Zip Code:_____

Email:_____ Date of Birth:_____

Allergies:_____

What medications are you currently taking?_____

Are you pregnant or lactating?_____

Physician's Name:_____

Are you part of the Brilliant Distinctions Program? (Please Circle) YES NO
If so what is your Brilliant Distinctions member number?_____
*****Brilliant Distinctions points can be deposited at appointments valued at $200.00 or more as per the terms and conditions of the Brilliant Distinctions program.**

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

| | | |
|---|---|---|
| Myasthenia Gravis | Vision Problems | Eaton Lambert Disorder |
| Hepatitis | Numbness | Muscle Weakness |
| Eye Disease | Amyotrophic Lateral Sclerosis | |
| Autoimmune Disease | (ALS) | |

Explain:_____

Previous Hospitalizations/Operations:_____

How will you be paying for today's appointment?_____

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 health/history, I will report it to Revitalize Medical as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member of Revitalize Medical responsible for any errors or omissions that I have made in the completion of this form.

**Patient Signature:_____ Date:_____**

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## INFORMED CONSENT

### 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 cause 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. I understand that the FDA has only approved Botox for the glabellar region and that injection into any other area other than the glabellar is considered off label use. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. 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 or discoloration; 2) post-treatment infection associated with any transcutaneous injection; 3) allergic reaction (Collagen); 4) reactivation of Herpes (cold sores); 5) lumpiness, visible yellow or white patches in approximately 20% of cases; 6) granuloma formation; 7) localized necrosis and/or sloughing (with scab and/or without scab), if blood vessel occlusion occurs. **Initial ____**

### 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. **Initial ____**

### Payment

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

### Results

I am aware that full correction is important and that follow-up touch-ups/treatments will be needed to maintain the full effects. I am aware that the duration of treatment is dependent upon many factors including, but not limited to, age, sex, tissue condition, my general health and lifestyle conditions, and sun exposure. I have been instructed in and understand post-treatment instructions and have been given a copy of them. I hereby voluntarily consent to treatment. The procedure(s) 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 am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.**

_____

Doctor Name (Print) Doctor Signature Date