CONSENT form BOTULINUM TOXIN TYPE A

I confirm that _____DR Amrit Takhar_____

who uses Botulinum Toxin Type A for cosmetic treatments has given me sufficient information to enable me to understand the use of the product. I have received information regarding the product's contra-indications and potential side effects. I have been given the opportunity to ask questions about the proposed treatment.
When completing the medical history questionnaire, I have answered the question fully and to the best of my ability. I have also given further details relating to my medical history when asked.

I confirm I have been informed that:

Botulinum Toxin Type A is injected into the skin to correct wrinkles and lines of the forehead, around the eyes and in between the brow. Due to the use of a needle, there may be some bleeding at the injection site and some pain/burning/stinging, swelling or bruising may be observed in association with the injection. This reaction may last for several days. Rarely headache, face pain, lowered eyelids and local muscle weakness have been reported. The risk of this is minimised by the injection techniques used

If any of these symptoms persist for more than one week, or if any other side effects develop please report them to Dr Takhar so that any necessary advice and help can be given

The effects of Botulinum Toxin Type A last for an average of 3-4 months but will vary depending on the condition of the skin, area treated, amount of product injected, injection technique and lifestyle factors such as sun exposure and smoking.

After treatment, please avoid alcohol consumption and strenuous exercise to reduce bruising risk. Avoid applying make up for 4 hours. Please avoid extreme sun exposure, UV light, freezing temperatures and saunas for 2 weeks after treatment.

Statement of consent: I have been correctly informed about the treatment effects and I consent to the treatment detailed on this form.

Signed:_____ Name:

Date:_____

MEDICAL QUESTIONNAIRE:

Are you currently receiving any medical treatment? Y ( ) N ( )

Do you suffer from any allergies? Y ( ) N ( )

Have you previously received any aesthetic treatments
(e.g. botox , fillers, laser, dermabrasion etc.) Y ( ) N ( )

Have you ever tested positive for HIV or Hepatitis? Y ( ) N ( )

DO you suffer from keloid or hypertrophic scarring? Y ( ) N ( )

Do you have a phobia of needles or suffer from fainting attacks? Y ( ) N ( )

Do you have any cutaneous (skin) infection or inflammatory problems
(e.g. herpes, acne etc) Y ( ) N ( )

Do you suffer from myasthenia gravis or Eaton Lambert syndrome? Y ( ) N ( )

Are you pregnant or breast feeding? Y ( ) N ( )

Treatment Notes

Date___/___/__ Areas Treated: _____
_ Product Type: _____
Lot No: _____
Notes: _____

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_ Product Type: _____
Lot No: _____
Notes: _____