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NEUROTOXIN INJECTION

REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT: _____ DATE: _____/_____/_____

I understand that the above named procedure has been explained and is to be performed on me.

The following has been explained to me in general terms and I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is undesirable wrinkling; muscle hyperactivity, spasm, or paralysis.

2. The **NATURE OF THE PROCEDURE** is to attempt to decrease muscle activity which causes functional wrinkles or asymmetry within the facial area. This is accomplished by injecting very small quantities of Neurotoxin (purified botulinum toxin) into the individual muscles. These treatments are NOT PERMANANT and require re-treatment of the area every 3-6 months if the effect is to be maintained. Only FDA approved neurotoxins are used, but they may be used for both ON-LABEL and OFF-LABEL indications. Treatments require no anesthesia.

3. The **PURPOSE OF THIS PROCEDURE** is to decrease wrinkling, muscle spasm, or hyperactivity in the facial area.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** includes doing nothing and accepting the circumstances of my condition. If I choose not to have the above named procedure, my condition may get worse, better, or stay the same. Sun exposure, aging, alcohol consumption and smoking among other factors may all contribute to future changes in my condition.

5. **RISKS FOR THIS PROCEDURE INCLUDE** (but are not limited to): bruising; swelling; allergic reaction to the medication; pain on injection; inadequate effect; drooping of the eyebrow, eyelid or soft tissue; loss of facial expression; asymmetry; creation of different facial wrinkles; and headache. **YOU SHOULD NOT HAVE THIS TREATMENT IF YOU ARE PREGNANT**, **BREASTFEEDING; HAVE A DISEASE AFFECTING YOUR MUSCLES AND NERVES (ALS-LOU GEHRIG'S DISEASE, MYASTHENIA GRAVIS OR LAMBERT-EATON SYNDROME) OR HAVE ALLERGIES TO ALBUMIN (in eggs); COW'S MILK PROTEIN; OR HAD AN ALLERGIC REACTION TO ANY BOTULINUM TOXIN PRODUCT. TELL YOU DOCTOR IF YOU HAVE CONDITIONS SUCH AS:** breathing problems (asthma or emphysema), swallowing problems, bleeding problems, diabetes, a slow heart beat or other problem with your heart rate and rhythm, plans to have surgery, had surgery on your face, weakness of your forehead muscles (such as trouble raising your eyebrows), drooping eyelids or any other change in the way your face normally looks.

Initials _____(Person signing)

SPREAD OF TOXIN EFFECTS: In some cases, the effects of all botulinum toxin products may affect areas of the body away from the injection site. These effects can cause symptoms of a serious condition called botulism. Symptoms of botulism can happen hours to weeks after injection and may include swallowing and breathing problems, loss of strength and muscle weakness all over the body, double vision, blurred vision and drooping eyelids, hoarseness or change or loss of voice, trouble saying words clearly, or loss of bladder control. Swallowing and breathing problems can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children and adults treated for muscle spasms, particularly in those patients who have underlying medical conditions that could make these symptoms more likely. The toxic effects have been reported at doses similar to those used to treat muscle spasms in the neck. Lower doses, in both approved and unapproved uses, have also caused toxic effects. This includes treatment of children and adults for muscle spasms. These effects could make it unsafe for you to drive a car, operate machinery, or do other dangerous activities.

6. Even though the risks and complications cited above are infrequent, they are the ones peculiar to the procedure and are of greatest concern.

7. I understand that my expectations should be realistic and I should consider not undergoing the procedure if my expectations are greater than the reality of this treatment. Psychological problems may occur due to unrealistic expectations of the procedure or difficulties in accepting changes in my appearance.

8. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE.

9. I consent to the taking of pictures during the course of my treatment for the purpose of helping to plan and assess the proposed therapy. No photographs will be shown to patients or physicians without my permission. If any portion of my surgery is to be billed to insurance (this does not include cosmetic procedures), I understand my insurance carrier may require photographs to process my claim.

10. I voluntarily consent to allow Dr. Gerstle and all medical personnel under his direct supervision and control and all other personnel who may otherwise be involved in performing such procedures to perform the procedure(s) described or otherwise referred to herein.

12. BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY.

Signature of person giving consent:_____ Date: _____

Relationship to patient if not the patient:_____

Witness:_____ Date: _____

SUBSEQUENT TREATMENTS:

Consent reviewed	Date	Consent reviewed	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____