DERMAL FILLERS- INFORMED CONSENT

Patient Name____ DOB________________________

Signature____ Date________________________

RN Signature ____

This form is to gain informed consent regarding Dermal Filler Injections. It is important that you are informed about your skin condition and proposed treatment. These include potential benefits and risks. This disclosure is not to alarm you, it is simply to better inform you so that you may give or withhold your consent to the treatment program. Dermal fillers are not used in persons under 18 years of age.

Dermal fillers are commonly used to smooth out folds and wrinkles, add volume to lips, and contour facial features due to loss of fullness due to aging, sun exposure, weight loss or illness. Dermal filler injectable gel is made from hyaluronic acid (HA) with a local anaesthetic, lidocaine 0.3%. Over time our body gradually degrades the HA gel. The effect of dermal filler generally last 6 months though in some people it will last longer. There are rare cases of a person's body degrading the HA gel faster.

RISKS OF DERMAL FILLER TREATMENTS:

1. Redness, swelling, bruising, tenderness or itching sensation in treatment areas. Occasionally bumps and pimples accompanied by redness may occur a few days post injecting. These common side effects typically resolve within a few days.
2. Infection: Post treatment bacterial, viral and/or fungal infections can occur which in most cases can be easily treated. In rare cases a permanent scar in the area can occur.
3. Rare cases of discolouration at injection sites – blue hue.
4. Rare cases of abscess, granuloma and blocking of blood vessels causing severe damage to surrounding skin have been reported.
5. Failure to achieve desired result.
6. Allergic rection.
7. Keloid formation/hypertrophic scarring (dermal fillers are not indicated in individuals who are susceptible to hyper keloid formation).
8. Very rare cases of blindness due to occlusion of a vessel have been reported.

Any inflammation or other minor reactions lasting more than 1 week, the prescribing doctor should be informed to ensure appropriate action is taken.

Pre-treatment Checklist

Are you currently under a doctor's care for any medical condition such as but not limited to diabetes, epilepsy, porphyria (enzyme disorder) or an auto-immune disease? **Yes / No**

If yes, please give details: ____

Are you taking blood thinners including herbal treatments? **Yes / No**

Are you pregnant or breastfeeding? **Yes / No**

Do you have recent signs of inflammation or infection to the area being treated? **Yes / No**

Do you have history of ANY allergies or to Lidocaine or other topical anaesthetic? **Yes / No**

Do you have a chronic disease of any kind? **Yes / No**

Have you ever had any facial surgery OR cosmetic facial procedures? **Yes / No**

Have you ever suffered from cold sores? **Yes / No**

Have you ever had a dermal filler (permanent or non-permanent)? **Yes / No**

Have you ever had an adverse reaction to hyaluronic acid? **Yes / No**

Do you have current active perioral or facial dermatitis? **Yes / No**

Do you have current active acne? **Yes / No**

Have you had recent dental work? **Yes / No**

I agree to inform the clinic of any changes to my medical information.

Do you consent to having photos taken and used for advertising, brochures or online material? **Yes / No**

Acknowledgement: The practice of medicine is not an exact science, and no guarantees can be or have been made concerning the expected results. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosure. In relation to my initial and all subsequent treatments, I have read the foregoing consent and hereby confirm that I have 1) had each item explained to me, 2) was given an opportunity to ask questions, and 3) had all my questions answered. I hereby authorise the clinician (Registered Nurse/Doctor) to perform the procedure of DERMAL FILLER injections. I hereby release my clinician, the facility and the doctor from liability associated with this procedure. I am over 18 years of age. I agree that photos may be taken as part of my treatment record. I understand that treatments for cosmetic procedures are not able to be claimed on Medicare or Private Health Funds. I hereby give my informed consent to proceed with the dermal filler injections and other agreed treatment(s).