



# Thurloe Street Dental.

**Thurloe Street Dental**

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***BOTOX PATIENT CONSENT FORM***

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Other Contact Number: \_\_\_\_\_

Other relevant details: \_\_\_\_\_

**THE FOLLOWING POTENTIAL ADVERSE EVENTS HAVE BEEN FULLY EXPLAINED AND UNDERSTOOD BY ME**

|  |  |
|--|--|
| Mild swelling at the injection site  |  |
| Headache   |  |
| Localised Numbness   |  |
| Bruising   |  |
| Rash   |  |
| Temporary loss of function of the near-by muscles (e.g. ptosis / drooping lid) |  |
| Other  |  |

**I confirm that Allysun Ramsdale (under the prescription of a qualified prescriber)**

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 questions fully and to the best of my ability. I have also given further details relating to my medical history, when asked.

**I confirm that 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. As is expected for any injection procedure, pain/burning/stinging, swelling and/or bruising may be observed in association with the injection. This reaction may last for several days. Rarely headache, lowered eyelids, face pain, bruising, local muscle weakness have been reported. Further information is contained in the patient information leaflet provided with the product.

If any of these symptoms persist for more than one week, or if any other side effects develop please report them to the practitioner as soon as possible as they are the best placed to help and advise you.

The aesthetic 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 applying make-up 4-6 hours. Please avoid extreme sun exposure, UV light, freezing temperatures and saunas for 2 weeks after treatment. Please follow all aftercare advice on the sheet you will be given for best results.

**CONTRAINDICATIONS:**

**You cannot receive Botox/Dysport/Vistabel if you are in the following categories:**

Pregnant or Breast Feeding

Neuromuscular disorders/Myasthenia Gravis/Eaton Lambert Syndrome

Blood Coagulation Disorders or taking anticoagulants

Currently taking Amino Glycoside Antibiotics, Spectinomycin or Muscle relaxants

**PATIENT CONSENT:**

I have received information about Botulinum Toxin<sup>®</sup>, which I have read and understood.

All aspects of treatment with Botulinum Toxin have been explained to me and I have discussed the treatment fully with my practitioner (including reasonably foreseeable risks associated with BOTULINUM TOXIN injections). I understand the importance of medical review at 2 weeks (or as advised by my physician).

I consent to receiving Botulinum Toxin which I understand is licensed for cosmetic use (specifically for the treatment of glabellar lines – the vertical lines between my eyebrows and peri orbital lines –around the eyes). If my practitioner is recommending additional areas for treatment with BOTULINUM TOXIN®, I understand that BOTULINUM TOXIN® is not licensed for these and I have discussed this with my practitioner.

I understand that the practice of medicine and surgery is not an exact science and therefore that no guarantee can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no guarantee that the anticipated results will be achieved.

**Patient's Signature:** .....

**Date:** .....

**Allysun Ramsdale (Practitioner) Signature :** .....

**Date:** .....

**PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONNAIRE**

Are you pregnant or breastfeeding?

Y ( ) N ( )

Have you a history of severe allergy/anaphylaxis?

Y ( ) N ( )

Are you currently receiving any medical treatment?

Y ( ) N ( )

If yes, please give details:

.....

Have you previously received any non- injectable facial aesthetic treatments (e.g. laser, dermabrasion, peels etc.)?

Y ( ) N ( )

If yes, please give details:

.....

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 ( )

Have you previously had any dermal filler treatment or Botulinum toxin?

Y ( ) N ( )

If yes, which treatment did you receive, what areas were treated and when:

.....

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 ( )

Do you suffer from any allergies?

Y ( ) N ( )

If yes, please give details:

.....

***If the answer is yes to any of the above, your practitioner may ask for further details.***

***Treatment may be refused if it is not considered to be in your own interest to proceed.***