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## INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

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**PATIENT** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE** \_\_\_\_\_

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is Important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

### THE 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 botulin um 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. 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** \_\_\_\_\_

### RISKSA NO COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. 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, 2. Double vision, 3. A weakened tear duct, 4. Post treatment bacterial, and/or fungal infection requiring further treatment, s. Allergic reaction, 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache and 9. Flu-like symptoms may occur.

**Initial** \_\_\_\_\_

### PREGNANCY, ALLERGIE &NEUROLOGI DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin.

**Initial** \_\_\_\_\_

### ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

**Initial** \_\_\_\_\_

**PAYMENT**

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

**Initial** \_\_\_\_\_

**RIGHT TO DISCONTINUE TREATMENT**

I understand that I have the right to discontinue treatment at any time.

**Initial** \_\_\_\_\_

**BOTULINUM TOXIN (BOTOX®)***Pre-Treatment Instructions*

In an ideal situation it is prudent to follow some simple guidelines before treatment that can make all the difference between a fair result or great result, by reducing some possible side effects associated with the injections. We realize this is not always possible; however, minimizing these risks is always desirable.

- Patient must be in good health with no active skin infections in the areas to be treated
- Patient should not be needle phobic
- Avoid alcoholic beverages at least 24 hours prior to treatment Alcohol may thin the blood, which will increase the risk of bruising.
- Avoid anti-inflammatory/ blood thinning medications ideally, for a period of two (2) weeks before treatment. Medications and supplements such as Aspirin, Vitamin E, Gingo Biloba, St. John's Wort, Ibuprofen, Motrin, Advil, Aleve, Vioxx, and other NSAIDS are all blood thinning and can increase the risk of bruising/swelling after injections .
- Schedule Botox® appointment at least 2 weeks prior to a special event which may be occurring, i.e., wedding, vacation, etc. etc. It is not desirable to have a very special event occurring and be bruised from an injection, which could have been avoided.

**BOTULINUM TOXIN (BOTOX®)***Post-Treatment Instructions*

The guidelines to follow post treatment have been followed for years, and are still employed today to prevent the possible side effect of ptosis (drooping of the eyelids). These measures should minimize the possibility of ptosis.

- No straining, heavy lifting, vigorous exercise for 3-4 hours following treatment. It is now known that it takes the toxin approximately 2 hours to bind itself to the nerve to start its work, and because we do not want to increase circulation to that area to wash away the Botox® from where it was injected.
- Avoid manipulation of area for 3-4 hours following treatment. (For the same reasons listed above.) This includes not doing a facial, peel, or micro-dermabrasion after treatment with Botox®. A facial, peel, or micro-dermabrasion can be done in same appointment only if they are done before the Botox® .
- Facial exercises in the injected areas is recommended for 1-hour following treatment. This is to stimulate the binding of the toxin only to the localized area.
- It can take 2 -10 days to take full effect. It is recommended that the patient contact the office no later than 2 weeks after treatment if desired effect was not achieved and no sooner to give the toxin time to work.
- Makeup may be applied before leaving the office.

## **INFORMED CONSENT FOR DERMAL FILLER TREATMENT**

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**PATIENT** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE** \_\_\_\_\_

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

### **THE TREATMENT**

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

**Initial** \_\_\_\_\_

### **RISKS AND COMPLICATIONS**

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. 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, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

**Initial** \_\_\_\_\_

### **PREGNANCY AND ALLERGIES**

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

### **ALTERNATIVE PROCEDURES**

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

**Initial** \_\_\_\_\_

### **PAYMENT**

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

**Initial** \_\_\_\_\_

### **RIGHT TO DISCONTINUE TREATMENT**

I understand that I have the right to discontinue treatment at any time.

**Initial** \_\_\_\_\_

### **TRAINING COURSE**

I understand that I have volunteered to be a model patient in a training course and the doctor/healthcare professional who will be treating me has had limited experience with the method of treatment.

**Initial** \_\_\_\_\_



## **PRE-TREATMENT INSTRUCTIONS**

### *Dermal filler treatment*

A few simple guidelines before your treatment can make a difference between a good result and a fantastic one.

- Patient should be in good overall health. A full medical and dental history must be performed on all patients for optimal results.
- If you develop a cold sore, blemish, or rash, etc. prior to your appointment you must reschedule.
- If you have a special event or vacation coming up schedule your treatment at least 2 weeks in advance.
- Let us know if you are prone to cold sores - a pre-operative medication may help prevent cold sores after treatment.
- **AVOID:** Alcohol, caffeine, motrin, ginkgo biloba, garlic, flax oil, cod liver oil, vitamin A, vitamin E, fatty acids, niacin supplements, high-sodium foods, high sugar foods, refined carbohydrates, spicy foods, or cigarettes 24 hours before your treatment. This is to reduce the incidence of bruising after these procedures.
- Discontinue Retin-A two (2) days before and two (2) days after treatment.

## **POST TREATMENT INSTRUCTIONS**

### *Dermal Filler Treatment*

**DO NOT:** touch, press, rub or manipulate the implanted areas for the rest of the day after treatment. Avoid kissing, puckering and sucking movements for the rest of the day as these motor movements can undesirably displace the implanted dermal filler material. Irritation, sores, and post-operative complications including scarring are possible if you manipulate the dermal filler implants.

**AVOID:** Alcohol, caffeine, motrin, ginkgo biloba, garlic, flax oil, cod liver oil, vitamin A, vitamin E, fatty acids, niacin supplements, high-sodium foods, high sugar foods, refined carbohydrates, spicy food s, or cigarettes 24 hours before your treatment. This is to reduce the incidence of bruising after these procedures.

**AVOID:** Vigorous exercise and sun and heat exposure for 3 days after treatment.

**DISCONTINUE:** Retin - A 2 days after treatment. It is best to wear no makeup or lipstick until the next day. Earlier use can cause pustules.

- One side may heal faster than the other side.
- You can expect some bruising and swelling around the areas that were injected. Apply ice for the first hour after treatment for ten minutes on and ten minutes off.
- You must wait 2 weeks before any enhancements.

*\*\*\*Please report any redness, blisters, or itching immediately if it occurs after treatment. \*\*\**

I certify that I have been counseled in post-treatment instructions and have been given written instructions as well.

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Patient Signature

Date