Skin OKC Studio

BOTULISM TOXIN TYPE A CONSENT FORM
BOTOX, DYSPORT, XEOMIN

Botox, Dysport and Xeomin is made from Botulism Toxin Type A; a protein produced by the bacterium Clostridiu, botulinum. For the purpose of improving the appearance of wrinkles, small doses of the toxin are injected into the affected muscles blocking the release of a chemical that would otherwise signal the muscle to contract. The toxin thus paralyzes or weakens the injected muscle. The treatment begins to work in 24 to 48 hours with results lasting up to 3-4 months. The Food and Drug Administration (FDA) have approved the cosmetic use of Botulinum Toxin Type A for the temporary relief of moderate to severe frown lines between the brow recommends that the procedure be performed no more frequently than once every three months. Botox has also been approved for crossed eyes (strabismus), eyelid spasm (blepharospasm), cervical dystonia (spastic muscle disorder of the neck), motor disorders of the facial nerve (VII Cranial nerve) and Hyperhidrosis (severe under arm sweating).

It is not known whether Botulinum A Toxin can cause fetal harm when administered to pregnant women or can affect reproductive capabilities. It is also not known if Botulinum A Toxin is excreted in human milk. For these reasons Botulinum A Toxin should not be used on pregnant or lactating women.
I authorize and direct _____, MD, or Tonya Cameron RN CMP to perform the following procedure of Botulinum A Toxin injection(s) on _____ (Patient Name)
For the treatment of _____. (brow, forehead, crow's feet, lip lines)

Read and initial below:
___ The details of this procedure have been explained to me in terms that I understand.
___ Alternative methods and their benefits and disadvantages have been explained to me.
___ I understand that the FDA has only approved the cosmetic use of Botulinum A Toxin injection(s) listed above and am aware that issues or complications can occur and include but are not limited to:

- Paralysis of nearby muscle that could interfere with opening the eye(s)
- Local numbness
- Headache, nausea, or flu like symptoms
- Swallowing, speech or respiratory disorders
- Swelling, bruising or redness at injection site
- Disorientation, double vision or past pointing
- Temporary asymmetrical appearance
- Abnormal or lack of facial expression
- Inability to smile when injected into the lower face
- Facial pain
- Product ineffectiveness

___ I understand and accept that the long term effects of repeated Botox Cosmetic are as yet unknown
___ Possible risks and complications that have been identified include but are not limited to.

- Muscle atrophy
- Nerve irritability
- Productions of antibodies and unknown effect to general health

___ I understand and accept the less common complications, including the remote risk of death or serious disability that exist with this procedure.
___ I am aware that smoking during the pre/post operative period could increase chances of complications.
___ I have informed the doctor and/or Tonya Cameron RN CMP (Injector RN) of all my known allergies.
___ I have informed the doctor and/or Tonya Cameron RN CMP of all the medications I am currently taking, including prescriptions, over the counter remedies, herbal therapies and any others.
___ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.
___ I am aware and accept no guarantees about the results of the procedure have been made or implied.
___ I have been informed of what to expect post-treatment, including but not limited to: estimated recovery time, anticipated activity level, and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.
___ I am not currently pregnant or nursing, and I understand that should I become pregnant while using this drug there are potential risks, including fetal malformation.
___ If pre- and postoperative photos and/or videos are taken for treatment purposes, I understand that these photos are the property of the MD and Tonya Cameron RN CMP (Injector RN).
___ I understand these photos will be used for scientific record keeping and/or used in a portfolio.
___ All my questions have been answered by the MD or Tonya Cameron RN CMP regarding this procedure.
___ I have been advised to seek immediate medical attention if swallowing, speech or respiratory disorders arise.

Patient Consent:
I certify that I have read and understand this treatment agreement and that all blanks are filled in prior to my signature,

_____ _____
Patient Signature and date Witness signature/date

_____ _____
Print Patient Name Print Witness Name

Physician Certification
I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered questions fully, and I believe that the patient fully understands what I have explained.

_____ Date_____
Physician signature

Copy was given to patient ____ _____
Date Initials

Original placed in chart ____ _____
Date Initials