



INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT for wrinkles

I _____ DOB _____

Hereby authorise Dr _____ to perform the procedure of TGA approved Botulinum Toxin treatment for the treatment of my facial lines, wrinkles and other areas as discussed with my dental practitioner.

I understand the nature of the treatment and that Botulinum Toxin will be injected into specific sites as discussed with Dr _____ for a therapeutic effect. I understand that some of this treatment is considered "off label" treatment as described to me by Dr _____

I understand that Botulinum Toxin is a therapeutic product to be administered by a properly trained clinician, and that it has gained TGA approval for the treatment of glabellar lines and primary hyperhidrosis of the axillae on 9 October 2003. In turn, I have provided Dr _____ with a completed medical history, including all of the medications, natural treatments and tablets that I might be taking.

I do NOT have any of the following conditions

1. Defective neuromuscular transmission disorders (ie motor neuron disease)
2. Infection at the site of injection
3. Glaucoma
4. Pregnancy
5. Lactation (breast feeding)

I understand that possible side effects include headaches, pain, burning or redness at the site of injection, some local muscle tenderness and in rare cases droopiness of an eyelid, lack of feeling and nausea.

I acknowledge that whilst certain benefits are likely, the result from this treatment

ACKNOWLEDGEMENT & CONSENT

1. I certify that I have been fully informed by my dentist and have carefully read all the information provided and that the proposed treatment and the alternatives have been explained to me by my dentist to my satisfaction. I understand the implications and consent to the proposed treatment.
2. I understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.
3. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my doctor.
4. I understand that it is important for me to continue to see my dentist. All teeth need to be maintained daily in a clean, hygienic manner. I understand that it is important for me to abide by the specific prescriptions and instructions given by my dentist.



5. I understand that poor oral hygiene, smoking, poor diet and failure to attend for regular check-ups may result in complications.
6. I fully understand that during and following the contemplated treatment, conditions may become apparent which warrant additional or alternative treatment. I understand that due to the inherent nature of medical procedures, in some instances we are only able to determine the actual cost once treatment has commenced, and changes to the original plan may be required.
7. I understand that estimate figures are valid for three months from the quotation date, but we will endeavour to inform you of any significant changes as soon as possible. Payment is required at the completion of each appointment.
8. I understand that regardless of what had been explained to me or my expectations, results and experiences vary from patient to patient.
9. I understand that treatment is complex at times, and my dentist may determine that specialist intervention is required at any stage during treatment.
- 10. I fully understand that if any complications occur, additional cost may be incurred.**

Patient Name:

Patient Signature

Date: