ALABAMA
PLASTIC AND RECONSTRUCTIVE SURGERY

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Facial Plastic Surgery

CONSENT: Botulinum toxin

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives botulinum toxin. This material serves as a supplement to the discussion you will have or have had with Dr. Raggio. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, please ask prior to signing this form.

THE TREATMENT

Botulinum toxin (Botox, Xeomin, Jeuveau or Dysport) is a neurotoxin produced by the bacterium *Clostridium*, which relaxes muscles on the face and neck associated with facial expression. Treatment with toxin can cause your facial expression lines, or wrinkles, to be less noticeable. Areas most frequently treated are a) glabellar area or frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) head and neck muscles. I consent to any "off-label" use of toxin, as well as the FDA-approved indications (e.g., glabella, forehead, crow's feet). Toxin is diluted to a very controlled solution and when injected into the muscles with a small needle, it is almost painless. Patients may feel a slight burning sensation while the solution is injected. Procedure takes about 20 minutes and the results can last up to 3-6 months.

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, and bruising, 2. Double vision, 3. A weakened tear duct, 4. Post treatment bacterial, and/or fungal infection requiring further treatment, 5. Allergic reaction, 6. Minor, temporary drop of the eyelid(s) in approximately 2% of injections, this usually lasts 3 weeks 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache 9. Flu-like symptoms may occur.

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I consent that I am not pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have any significant neurologic disease(s). I do not have any allergies to the toxin ingredients, or to human albumin. If I have a lactose allergy, I will let my doctor know not to use Dysport.

ALTERNATIVE PROCEDURES & RIGHT TO DISCONTINUE TREATMENT

Alternatives to this procedure (no treatment, dermal fillers, lasers, chemical peels, and surgery) have been fully explained to me.
I understand that I have the right to discontinue treatment at any time.

PAYMENT

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

RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2-10 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re-treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area(s) of the injections for the 2-hours post-injection period.
I understand this is an elective procedure and I hereby consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and Dr. Raggio and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the Dr. Blake Raggio &/or his staff immediately. I also state that I read and write in English.

Patient Name: _____ **Patient Signature:** _____ **Witness:** _____ **Date:** _____