

DERMAL FILLER CONSENT FORM

INSTRUCTIONS

This is an informed consent document that has been prepared to help inform you concerning Dermal Filler injections and the risks involved. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent at the bottom prior to your treatment.

INTRODUCTION

Dermal fillers are used to correct volume loss, shape, contour and reduce the appearance of fine and/or deep lines. They consist of Hyaluronic acid which is a naturally-occurring gel produced in the body, which is injected into the treatable area. Fillers consist of local anaesthetic gel which minimises discomfort. The results can often be seen immediately after injection and can last anything between 8-18 months.

RISKS OF DERMAL FILLER INJECTIONS

Every procedure involves a certain amount of risk, and it is important that you understand that risks involved. An individual's choice to undergo a procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your practitioner to make sure you understand the risks, potential complications, and consequences of dermal filler injections:

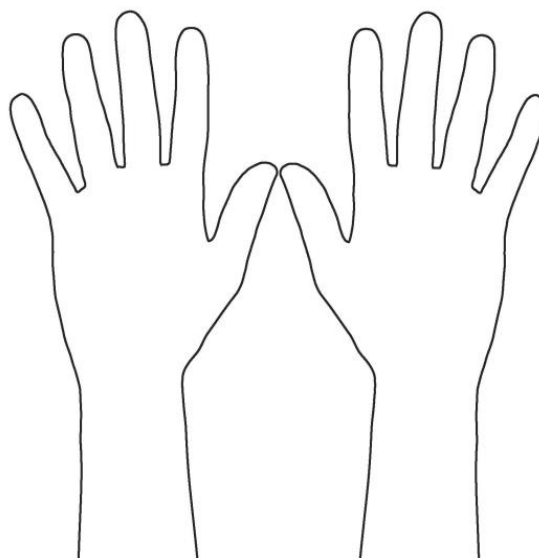
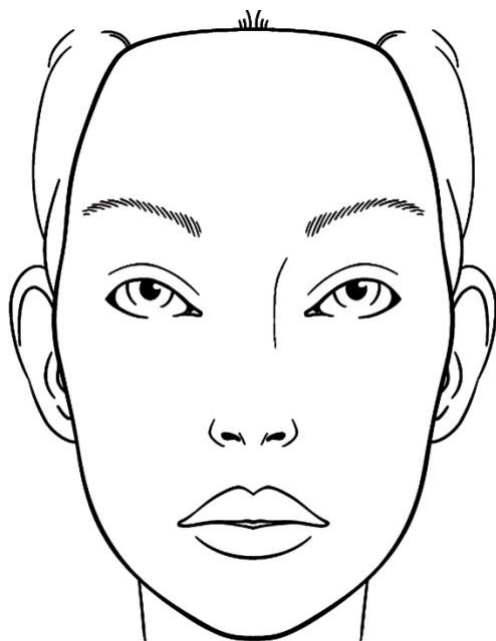
- **Bleeding**
- **Bruising/Swelling**
- **Infection**
- **Lumpiness**
- **Discolouration**

CAUTIONS & CONTRAINDICATIONS (To be checked with patient prior to treatment)

- **Pregnancy/Breastfeeding**
- **Infected skin area e.g. cold sores/cellulitis etc**
- **Anticoagulant use (e.g. Warfarin/Aspirin)**
- **Known hypersensitivity to hyaluronic acid or any of its excipients e.g. Lidocaine**

Photographs will be taken for documentation and will be stored electronically for reference purposes only and will not be passed on to any third party. Staff authorised by H&B Medical are trained in Data Protection and Clinical Governance and may process the files for storage only.

TREATMENT AREAS (Please mark out below)



Area treated	
Dermal Filler used	
Total number of Syringes used (attach sticker/s here)	
Complications	

Reason for treatment:

I have read a copy of the foregoing consent for the procedure, understand it, accept these facts, and hereby authorize to perform the procedure of Dermal Filler injections.

PATIENT'S NAME (Please Print): _____

PATIENT'S SIGNATURE: _____

DATE: _____

PRACTIONERS NAME (Please Print): _____

PRACTIONERS SIGNATURE: _____

DATE: _____