Donna Johnston, MD: Consent for injection of Dermal Filler

Patient's name: _____ Date of procedure: _____

Dermal fillers include: Radiesse, Juvederm, Belotero

As my patient, you have requested administration of a dermal filler for the correction of wrinkles on the face and undesired folds in the facial skin. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether or not to go forward with the procedure.

This product is administered via a syringe, or injection into the areas of the body sought to be filled with the filler to reduce the wrinkles. Multiple injections might be made depending on the site, depth of deformity, and technique used. Risks and complications include but are not limited to:

1. Facial bruising, redness, swelling, itching, and pain: These symptoms are usually mild and last less than a week, but can last longer. Some patients may experience additional swelling or tenderness at the implant site and rarely pustules may form. These reactions may last for as long as approximately 2 weeks.Patients who are using medications that can prolong bleeding such as aspirin, warfarin (coumadin), pradaxa, eliquis, or certain vitamins and supplements may experience bruising or bleeding at the injection site. _____ (initial)
2. Nodules, and palpable material: There is a risk of small lumps that may form under the skin, and I may be able to feel the product in areas where it has been injected. Any foreign material injected into the body may create the possibility of swelling or other local reactions to a filler material. _____(initial)
3. Unintentional injection into blood vessels can cause embolization, tissue necrosis, vision impairment, blindness, and stroke._____(initial)
4. Infection can occur at the injection sites._____(initial)
5. History of herpes: I understand that there is a risk that the injection of any filler material carries the risk of causing recurrence of an outbreak of herpes and that the outbreak may be severe in nature. I have disclosed to the health care provide my medical history, and in particular, disclosed prior herpes outbreaks._____ (initial)
6. Allergic reactions: I understand that dermal filler should not be used in patients with severe allergies, a history of anaphylaxis, or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients in the filler, especially hyaluronic acid and gram-positive bacterial outcome._____ (initial)
7. Migration: I understand that filler may move from the place where it is injected.
8. Duration of effect: I understand that the outcome of treatment will vary among patients. In some instances additional treatments may be necessary to achieve the desired outcome._____ (initial)

9. Concomitant dermal therapies: If you are considering laser treatment, chemical skin peeling, Ultherapy, or any other procedure based on a skin response after dermal filler, or if you have recently had such treatments and the skin has not healed completely, there is a possible risk of inflammatory reaction at the ste. _____ (initial)
10. Keloid/scarring: Filler in patients with known susceptibility to keloid formation or hypertrophic scarring is not recommended. _____ (initial)
11. Pregnancy: the safety of fillers has not been studied for use during pregnancy._____ (initial)

Most patients are pleased with the results of their filler, however, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatments to achieve the result you seek. While the effects of filler can vary from months to years, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to a year.

Consent: Your consent for this procedure is strictly voluntary. By signing this consent form, you hereby grant authority to your provider to perform facial injections with a filler. The nature and purpose of this procedure, as well as possible risks or complications of the procedure have been fully explained to your satisfaction and your questions have been answered. No guarantee has been given by anyone as to the results that may be obtained by this treatment. I understand that cosmetic procedures are not covered by insurance and agree to self-pay for this procedure.

I have read this informed consent and certify that I understand its contents in full. I hereby give my consent to this procedure.

Patient's name: _____

Patient's signature:_____ Date:_____

Witness/staff signature:_____ Date:_____

Physician/Provider signature:_____ Date:_____