east valley naturopathic doctors

Dysport/Botox Consent Form

Dysport/Botox is indicated for the temporary improvement in the appearance of facial wrinkles.

The most common side effects include swelling, redness, pain and bruising of the treated areas. These normally last less than seven days.

If you are pregnant, breastfeeding, or under 18, you should not use these medications.

I confirm that prior to treatment I have avoided aspirin, medications that thin the blood, non-steroidal anti-inflammatory medications, St. John's Wort, or high doses of Vitamin E. These medications may increase bruising or bleeding at the injection site.

I understand that there may be some degree of discomfort with these injections.

I understand that there are no guarantees as to the result of this treatment.

I understand that this is a cosmetic treatment, and that no medical claims are expressed or implied.

I understand that the results may take several days to be observable and generally lasts up to six months.

I understand that due to variables such as age and individual anatomy, "touch ups" may be necessary.

I understand that if I have a history of cold sores I will be given a prescription to prevent a possible outbreak that could occur following the injections.

I hereby agree to all of the above, and agree to be treated with Dysport/Botox. I further agree to follow all post-treatment instructions.

Post Dysport/Botox Instructions

1. Cold compresses may be used immediately after treatment to reduce swelling.

2. Avoid touching the treated area within six hours following treatment so that you do not accidentally injure your skin while the area is numb. After that, you may gently wash the area with soap and water.

3. Until there is no redness or swelling, avoid exposure of the treated area to intense heat (sun lamp or sun bathing).

4. Continue to avoid aspirin, medications that thin the blood, non-steroidal anti-inflammatory medications, St. John's Wort, or high doses of Vitamin E.

If you have any questions, please feel free to call the office at (480) 985-0000.

Patient Signature:_____Date:_____

Witness Signature: _____Date:_____