SOUTH COAST
UROGYNECOLOGY
THE LAGUNA LASER CENTER

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INFORMED CONSENT FOR RESTYLANE INJECTION

CLIENT NAME: _____ DATE: _____

I, the undersigned hereby give permission to the certified staff member to inject me with Restylane into the areas I have requested. I understand that there are no guarantees as to the result that may be obtained.

1. I may experience sensitivity, discomfort, swelling, or redness at the implantation site immediately following the treatment. Some patients may experience additional swelling, visible lumps, or pustules, which may last up to two weeks and may need to be treated with corticosteroids.
2. This treatment is not meant to be permanent. Its value is of relatively short duration. Touch-up treatments at 6 -12 month intervals are usually required to maintain maximum correction.
3. Any injection carries a risk of infection or reaction to the injection process. Mild bruising, a slight blush, itching or firmness may occur at the injection sites.
4. Although is not likely, if the needle should accidentally pierce a blood vessel, a scab, scar or temporary discoloration could form. If the material is accidentally injected into a blood vessel, a blockage of blood flow and loss of circulation to the area could result.
5. Extra care is required for patients with allergic reactions to other substances. Such people may be hypersensitive to products.
6. You must pre-treat with Anti-viral medications for a minimum of 3 days prior to treatment if you have a history of cold sores or herpes virus.
7. You must postpone treatment if you have any skin inflammation, even a pimple, cyst, rash or hives; or if you have any infection.
8. Safety of Restylane has not been proven during pregnancy.
9. In rare cases, scabs and skin sloughing at the site have resulted in a shallow scar. Also, rarely abscesses form at the site. This may be associated with antibodies and can reoccur. These may develop weeks or months after injection and can result in hardening and/or scars.
10. Systematic complaints which include flu-like symptoms such as fever, nausea, headache, joint aches, dizziness, rash, blurred vision, tingling and numbness, difficulty breathing, hypotension and tightness in the chest have been reported in fewer that 0.2% of Restylane patients.
11. Adverse reactions may occur in patients with systemic connective tissue disease such as rheumatoid arthritis, systemic lupus erythematosus, scleroderma and inflammatory disorders. There have been reports of clients developing these types of diseases after Restylane treatments. However, a casual relationship between Restylane injections and the onset of these diseases has not been established.
12. There is a possibility that other complications unknown at this time may develop in the future.
13. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

I have read the above and affirm that I fully understand and consent to receive the treatment at my own discretion.

CLIENT'S SIGNATURE _____ DATE: _____

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

Initials_____

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DERMAL FILLERS TREATMENT

Instructions

Pre-treatment requirements:
A few simple guidelines before your treatment can make a difference between a good result and a fantastic one.

- If you have a history of Herpes (cold sores) you must be treated 2 days prior and 8 days after treatment with Valtrex 500mg BID (twice a day) or Zovirax 400mg TID (three times a day).
- Reschedule if you have a cold sore, blemish, or rash, on your face before tx.
- If you have a special event or vacation coming up schedule your treatment at least 2 weeks in advance.
- NO Aspirin, Motrin or any other non-steroidal anti-inflammatory medications, St. John's Wort, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, high doses of Vitamin E, or any other essential fatty acids at least **1 week before and after treatment.**
- Discontinue Retin-A two (2) days before and two (2) days after treatment.
- AVOID: Alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, and cigarettes 24-48 hours before and after your treatment

Post treatment requirements:
After your treatment, you might have some redness and swelling. This will normally last less then seven days. Cold compresses may be used immediately after treatment to reduce swelling. If the inconvenience continues beyond seven days or if other reactions or side effects occur, please contact your physician.

- Avoid touching the treated area within six hours following treatment. After that, the area can be gently washed.
- Sunbathing and cold outdoor activities should be avoided until any redness or swelling disappears.
- If you have previously suffered from facial cold sores, there is a risk that the needle punctures could contribute to a recurrence. Speak to your physician about medications that may minimize a recurrence.
- Avoid exercise and alcohol for six hours after treatment.
- Having a follow-up treatment before the product has fully dissipated will maintain your refreshed appearance. Please be sure to consult your physician about recommendations for touch-up or follow-up treatments.

I certify that I have been counseled in post treatment instructions and have been given written instructions as well.

Patient Signature_____ **Date**_____

Witness Signature_____ **Date**_____

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DERMAL FILLER TREATMENT RECORD

Patient Name: _____D.O.B._____Date: _____

Reviewed all contraindications, warnings and precautions as stated in the physician package insert and the client's medical history. _____

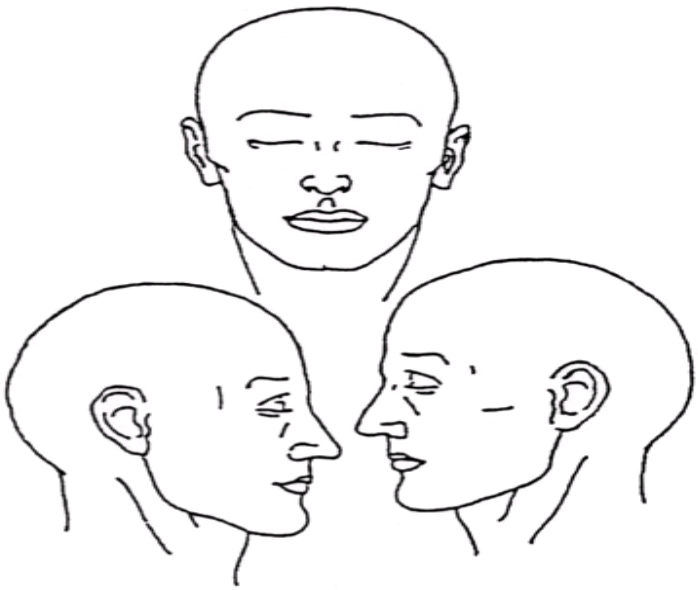
Patient denies NSAID's, Aspirin, Coumadin, Heparin or blood thinning agents in the last 7days. _____

Consent signed: _____ Date :_____

Anesthetic used:_____

Cool Packs given – Pre_____ Post _____

Affix Label here



Notes: _____

After care instructions reviewed and given. _____

Total C.C.'s Given: _____

Complications: _____

Clinician Signature: _____