**IADVL- Academy**

**SIG (Special Interest Group) Aesthetics 2020-21**

**CONSENT FORM FOR DERMAL FILLERS/SKIN BOOSTERS**

(Please acknowledge the source when using this consent form)

Mr/Mrs./Miss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the PROCEDURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Filler to be used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Batch No:

Date:

**Procedure Details:**

 **I HAVE BEEN INFORMED IN THE LANGUAGE I BEST UNDERSTAND THAT**

Dermal fillers/Skin Boosters are injectable gels which are injected under topical or local anaesthesia to reduce the signs of ageing or improving contours of face and body parts. The fillers are being used for these indications for more than a decade.

Different varieties of products are used for correction of facial lines, wrinkles and folds, lip enhancement and shaping facial contours. Fillers are also used to restore the elasticity of skin and reduce irregularities on the skin’s surface. The correct products and indications suitable for me have been explained to me.

The effect of the treatment with this product.................................................. can last for months/years and repeat treatments are necessary for sustaining long term results. The duration may be variable depending on the product used, area treated, skin type, and the metabolic variations of every patient. Follow up treatment will be mandatory to sustain the desired results in future.

**I AM ALSO INFORMED THAT**

* After the injection, sometimes swelling, redness, pain, lumps, bumps, bruising, allergic reactions or tenderness may be seen. Rare reactions such as late onset allergy, infections, obstruction of blood vessels, hypersensitivity or even loss of vision, neurological complications may occur. I understand the procedure, the risks, complications and after care.
* Variable results are seen due to the patients’ lifestyle, medical profile, age and the extent of severity of sagging which varies from person to person.
* All dermal fillers are not USFDA approved.
* Pre and post procedure photographs will be taken which may be used for academic or scientific purposes.
* This is not a complete treatment for my ailment and other forms of treatments may be needed for optimum results.

**COST AND PAYMENT**

I have been informed about the fees and the number of sessions / package. I shall abide by the same.

**Consent Letter:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her /his designated staff to perform procedure of Dermal Fillers/Skin Boosters. Further, my signature below indicates my consent for the treatment described and my agreement to comply with the requirements placed on me by this consent form.

I have informed the doctor about my medical history regarding herpes, allergy, acne, keloids, diabetes, and autoimmune disease, treatment with anticoagulants, NSAIDS, blood thinners or corticosteroids etc. I am not pregnant or breast-feeding. In spite of this, I am aware that I may develop any allergy at any point. I give my consent to the doctor to take the necessary measures to treat my allergic reaction, if any develops. Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.

I have been informed about the other alternative methods as well as their benefits and disadvantages.

I understand that for ideal results, this procedure can be combined with other treatments. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am also aware that follow-up treatments may be necessary for desired results. I understand the procedure, the risks, complications and after care.

My questions regarding the procedure have been answered satisfactorily.

I hereby release Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her/his designated staff from any liability and side effects associated with above procedure. The payment and fee structure have been informed to me and I agree to abide by the same. I also agree to comply with the recommended aftercare instructions.

**SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE (in case of minor)**

**Name:**

**SIGNATURE OF WITNESS SIGNATURE OF OPERATING DOCTOR**

**Name: Name:**

**Date: Time: Place:**

**Was Translation to the Patient’s language required: Yes/ No**

**SIGNATURE OF THE TRANSLATOR (Name and Relationship with the patient, if any)**

**POST PROCEDURE CARE:**

* Do not massage or manipulate injected areas for 24 hours after injections.  Washing your face and applying make-up is fine.
* Do not receive facial/ laser treatments or microdermabrasion after Filler injections for at least 10 days.
* Do not wear a headband or hat if you have had injections between the brows or in the forehead
* Refrain from aerobic exercise that increases your heart rate significantly (running, swimming, bicycling) for 24 hours following injections. Walking or other low impact forms of exercise are fine
* Refrain from using ibuprofen, aspirin, fish oil supplements, or vitamin E for 24 hours following injection
* If bruising appears, apply ice to the area for 15 minutes every hour to decrease bruising
* Dermal results shall show optimum result at 2 weeks.  We recommend scheduling a follow-up appointment 2 weeks after your injection.