Northwestern Medicine®

NORTHWESTERN MEDICAL GROUP
CONSENT FOR BOTOX®

Patient Name: ____ Date of Birth: ____________________________

1. I consent to the performance of Botox® injections on the above named patient. This is to be performed by or under the supervision of

   Dr. ______________________________________ who has explained to me:

   A. **The purpose and cosmetic nature of this procedure/treatment:** The injection of a very small amount of Botox®, a purified toxin produced by the bacterium clostridium botulinum, into the specific muscle causes weakness or paralysis of that muscle. This results in relaxation of the muscle and improvement of the lines or wrinkles that the muscle action has formed.
   B. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist. **Possible risks and complications of botox which may include:**
      1. Transient headache
      2. Swelling
      3. Bruising (Substances that increase this risk include Vitamin E, Aspirin, Motrin, other non-steroidal anti-inflammatory drugs and blood thinning medications such as Coumadin. I understand if I have taken any of these products in the past 7 days the procedure may not be recommended.)
      4. Pain during injection
      5. Twitching
      6. Itching or numbness
      7. Asymmetry (Unevenness) and/or temporary drooping of eyelids or eyebrows
   C. **Anticipated benefit:** Response is usually between 5-14 days after injection. Typically the muscle action (wrinkles) will return in 3-5 months. At this point a repeat treatment can relax the muscle and soften the lines again. I agree to follow up in 2-4 weeks after my first treatment if asked to do so by my physician.
2. I was informed this procedure is considered a cosmetic treatment. I was also informed that in a small number of individuals, the injection does not work as satisfactorily or for as long as usual. I understand there is no guarantee that any particular results will be obtained. Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for touch ups. I have had the opportunity to discuss this procedure with a physician and received answers to all questions I asked.
3. Botox® is best at treating dynamic facial lines, those caused by facial muscles activity; lines present at rest may or may not improve. I was also informed of possible alternative methods of treatment for wrinkles such as topical creams, chemical peels, laser, forehead/brow lift, facelift or hyaluronic acid treatments and the risks involved in these alternative methods.
4. I understand there is an increase in side effects if I do not follow certain instructions. These include:
   a. I will not lie down or bend forward for any extended periods of time for four hours post procedure.
   b. I will not manipulate or massage the treated area for at least 4 hours post procedure.
5. I understand that there are certain conditions when Botox® treatments are not recommended. These include:
   a. Neurological disease, such as myasthenia gravis
   b. Pregnancy or breastfeeding
6. I authorize the physician performing this procedure to obtain the assistance of other physicians (including residents and interns) as he/she considers advisable.
7. I would like a follow up call to check on my status? ☐ YES ☐ NO
8. I can be reached at: (   ) – OK to leave message? ☐ YES ☐ NO

I have read and fully understand this Botox consent. All the blank spaces were filled in before I signed the form.

____ _____________________________

Signature of Patient Date and Time

Statement of Physician

I certify that at the time the above consent was signed, the person who signed was capable of understanding the nature of the patient's physical condition and of the proposed diagnostic or therapeutic procedure; the risks involved in the proposed diagnostic or therapeutic procedure and any reasonable alternatives to the proposed diagnostic or therapeutic procedure; and the risks involved in refusal of the proposed diagnostic or therapeutic procedure.

I certify that I explained to the person signing this consent the items described in paragraph 2 of the consent to Diagnostic and Therapeutic Procedure, that I answered the signer's questions concerning them and that I witnessed the signature of the patient or other person authorized to consent for the incompetent patient named above.

____ Date _____________________________

Physician Name, MD

Physician Name, MD Scribe _____________________________