

BOTULINUM TOXIN TYPE A
(Botox Cosmetic)

Botox is made from the Botulinum Toxin Type A, a protein produced by the bacteria *Clostridium botulinum*. For the purpose of improving the appearance of wrinkles, small doses of the toxin are injected into the affected muscles blocking the release of a chemical that would otherwise signal the muscle to contract. The toxin thus paralyzes or weakens the injected muscle. The treatment usually begins to work within 24 to 48 hours, and can last up to four months. The Food and Drug Administration (FDA) approved the cosmetic use of Botulinum Toxin Type A for the temporary relief of moderate to severe frown lines between the brow and recommends that the procedure be performed no more frequently than once every 3 months.

It is not known whether Botulinum A toxin can cause fetal harm when administered to pregnant women or can affect reproduction capabilities. It is also not known if Botulinum A toxin is excreted in human milk. For these reasons, Botulinum A toxin should not be used on pregnant or lactating women for cosmetic purposes.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform the following procedure of Botulinum A Toxin injection(s) on _____ for the treatment of _____.

(patient name) (i.e., brow, forehead, "crow's feet", etc.)

Patient's
Initials

- _____ The details of the procedure have been explained to me in terms I understand.
- _____ Alternative methods and their benefits and disadvantages have been explained to me.
- _____ I understand that the FDA has only approved the cosmetic use of Botulinum A Toxin for frown lines between the brow. Any other cosmetic use is considered "off label".
- _____ I understand and accept the most likely risks and complications of Botulinum A Toxin injection(s) that include but are not limited to:
- Paralysis of a nearby muscle which could interfere with opening the eye(s)
 - Local numbness
 - Headache, nausea and/or flu-like symptoms
 - Abnormal and/or lack of facial expression
 - Facial pain
 - Swelling, bruising, and/or redness at injection sight
 - Disorientation, double vision, and/or past pointing
 - Temporary asymmetrical appearance
 - Swallowing, speech and/or respiratory disorders
 - Inability to smile when injected in the lower face
 - Product ineffective
- _____ I understand and accept that the long-term effects of repeated use of Botox Cosmetic are as yet unknown. Possible risks and complications that have been identified include but are not limited to:
- muscle atrophy
 - nerve irritability to general health
 - production of antibodies with unknown effect
- _____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with this procedure.
- _____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.
- _____ I have informed the doctor of all my known allergies.
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and any other.
- _____ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made or implied.

_____ I have been informed of what to expect post-treatment, including but not limited to: estimated recovery time, anticipated activity level, and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.

_____ I am not currently pregnant or nursing and I understand that should I become pregnant while using this drug there are potential risks, including fetal malformation.

_____ If pre- and post-operative photos and/or videos are taken of the treatment for record purposes, I understand that these photos will be the property of the attending physician.

_____ I understand that these photos may only be used for scientific or record keeping purposes.

_____ The doctor has answered all of my questions regarding this procedure.

_____ I have been advised to seek immediate medical attention if swallowing, speech or respiratory disorders arise.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

Patient Signature / Date

Witness Signature / Date

Print Patient Name

Print Witness Name

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

Physician Signature / Date

_____ copy given to patient
initial

_____ original placed in chart
initial