Consent for treatment with Botulinum Toxin Treatment (Xeomin)

Patient name: **DOB:**

Treating practitioner name: **Provider no.:**

Treatment date/location: at Victorian Cosmetic Institute L1/268 Manningham Road, Lower Templestowe, 3107

I, , understand;

- What the procedure involves and the possible risks compared to the potential benefits
- This is an elective cosmetic procedure
- The alternative treatments options, and their risks and benefits including no treatment. I understand the potential risks of not undergoing treatment, including the natural progression of the condition being addressed.
- That today's Xeomin treatment may include *off-label* use, meaning it's used outside its approved indications.
- Results vary depending on anatomy, muscle strength, and injection technique. Results are not and cannot be guaranteed.
- If I choose a lower dose (e.g. for cost reasons), the result may be less effective or shorter-lasting, and I accept that outcome.

I've discussed any medical conditions that may affect treatment with my practitioner. Specifically, I confirm I am **not** pregnant and do **not** have myasthenia gravis or Eaton-Lambert syndrome.

Treatment table

Area to be treated	Frown	Forehead	Crows feet	Brow lift	Upper lip	Mouth Depressors	Chin	Masseters	Other:
Number of units									
Aim: Freeze (F) reduce (R)	F R	F R	F R		F R	F R	F R	F R	

The total number of Xeomin units that will be administered is _____Units. Price $_____

Suggested treatment interval (circle); 3 3.5 4 6 months

Risks and side effects

*I understand and accept the **common side effects and risks** associated with treatment, including:*

- Swelling and bruising
- Pain and tenderness during and after treatment
- Headache
- Uneven or unexpected cosmetic results (e.g over- or under-treatment)
- Eyebrow heaviness or droop, usually associated with forehead treatment.
- An undesirable effect on natural facial expressions, including changes to your smile.

*I understand and accept the following **uncommon and rare side effects and risks** with the treatment, including:*

- Eyelid droop (lasting the duration of the treatment effect)
- Partial loss of function of the mouth
- Infection of the injection site(s)
- Difficulty with swallowing (neck treatments only)
- Reduced effectiveness due to antibody formation, either from this treatment or previous treatments
- Botulinum toxin toxicity from overdosage

Post-treatment agreement

To potentially reduce risks and side effects,I will agree to;

- Stay upright and avoid lying down for 4 hours
- Avoid exercise for the rest of the day
- NOT massage or press the treated areas for 24 hours

Review of outcomes and top-up policy

- The review should occur while the effects are still present (and ideally within 1-4 weeks).
- Concerns raised after the effects have worn off may not be considered valid.

Acknowledgment of consent

- I have read and understood this consent form
- I have had enough time to discuss the treatment and ask questions
- All my questions were answered satisfactorily
- No treatment was performed before signing this form
- I am choosing to proceed voluntarily, without pressure or coercion
- I understand my practitioner may use AI scribe to dictate my appointment
- *I give my full, informed consent to proceed with treatment today.*

If you would like a copy of this form emailed to you, please circle: No / Yes **Email: _____**

Name of patient: **Patients signature: _____**
Date:

Practitioner: **Practitioner signature: _____**
Date:
Scripting practitioner (if applicable):

My treating practitioner can be contacted on 1300 863 824 or alternatively I can email . In the event that I can not contact , I should email drgavinchan@vci.com.au or drtalhamajoka@vci.com.au should I be experiencing any problems or concerns after treatment.