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BOTOX® Treatment CONSENT FORM

Please read and initial each statement.

I have read the **Botox® Information and After Care Instructions** and have had an opportunity to ask questions about the treatment and I am satisfied with the answers. _____

I authorize the physician or nurse to administer Botox® treatments to me. _____

The cost of treatment has been discussed with me and I agree to pay this amount. _____

I understand:

- there may be temporary side effects such as a **transient headache, swelling, bruising, pain** during injection, **twitching, itching, numbness, asymmetry** (unevenness), **drooping of eyelids, eyebrows** or the possibility of **infection**. There may risks not yet known at this time. _____
- Botox® treats active facial wrinkles temporarily (**4 months**). The effect gradually wears off. Wrinkles present at rest (i.e. no muscle use) are not affected by Botox® but may soften. The effect of Botox® for excessive sweating (hyperhidrosis) or migraines also lasts for **4 months**. _____
- there are other options for treatment including not having the treatment _____
- Botox® treatments are not recommended during pregnancy or breastfeeding or in the presence of neurological diseases like myasthenia gravis. I do not have any of these conditions. _____
- the risk of side effects may increase with other medical conditions such as immunocompromised situations (diabetes, HIV, smoking, being on immune suppressants such as prednisone) or bleeding disorders and with the use of certain medications that increase the risk of bleeding (aspirin, coumadin, Plavix, vitamin E, ibuprofen and other non-steroidal anti-inflammatories). None of these conditions apply to me. If they do I realize I am at increased risk of side effects. I will inform the nurse or physician if my medical condition changes over the course of treatment. _____

- there may be an increased occurrence of side effects if I do not follow the aftercare instructions. _____
- I will arrange for follow-up in **2 to 3 weeks** after my first treatment. Possible touch-ups may be recommended and an additional charge will apply. _____

I authorize the taking of clinical photographs for:
(not required for hyperhidrosis/migraine treatment)

- my clinic record _____
- research and education (discretion applied) _____
- publication _____
- the U Cosmetic website (discretion applied) _____
- the U Cosmetic Brag Book kept in the clinic (discretion applied) _____

I have read and understand the **Botox® Treatment Consent Form**. My questions have been answered satisfactorily by the doctor or nurse. I accept the risks and complications of the procedure.

Patient name (please print) Date Signature

Witness name (please print) Date Signature

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