

**High Plains Plastic & Reconstructive Surgery  
&  
Sensei Med Spa**

**Botulinum Injection Therapy Consent Form  
(Botox Cosmetic® and Dysport®)**

Please initial each section to indicate that you Understand each topic. Do not initial if you desire more information.

**Proposed Treatment**

Injection of a very small amount of Botulinum Into the specific muscles causes weakness or Or paralysis of that muscle. This results in Relaxation of the muscle and improvement of The lines of wrinkles that the muscle action has formed Initial \_\_\_\_\_

**Anticipated Benefit**

Response usually is seen 2-10 days after injection. Typically, the muscle action (and wrinkles) will Return in 3-5 months. At this point, a repeat Treatment will relax the muscle and soften the Lines again. Initial \_\_\_\_\_

**Risks and Complications**

Possible side effects include: transient headache, Swelling, bruising, pain during injection, Twitching, itching, numbness, asymmetry (unevenness), temporary drooping of eyelids or eyebrows. These side effects are rare, but have been reported. In a very small number of individuals, the injection does not work as Satisfactorily or for as long as usual. Known Significant risks have been disclosed, yet the Theoretical risk of unknown complications does exist. Initial \_\_\_\_\_

Bruising may occur after Botox or Dysport Injections. Substances that increase the risk Of bruising include Vitamin E, aspirin, motrin And other non-steroidal anti-inflammatory drugs. I understand that if I have taken any of the above within the past 7 days, I have an increased risk of bruising. Bruising is also a significant risk with the use of blood thinning medications such as coumadin. I understand that if I am taking a blood thinning medication, this treatment my result in significant bruising and May not be recommended. Initial \_\_\_\_\_

I understand that there may be a higher Possibility of side effects if I do not follow Certain instructions and will adhere to these Instructions for at least 4 hours from the time of Treatment. These include:

\* I will not lie down or bend forward for extended periods of time for at least 4 hours from the time of treatment.

\*I will not manipulate or massage the treated area for at least 4 hours after the treatment.

Initial \_\_\_\_\_

**Pregnancy & Nuerological Disease**

I understand that there are certain conditions Where Botulinum therapy treatments are not recommended. These include:

\* Neurological disease, such as myasthenia gravis

\*Pregnancy or breastfeeding

None of the conditions above apply to me

Initial \_\_\_\_\_

**Limitations and Alternatives**

Botulinum toxin therapy is best at treating dynamic Facial lines, those caused by facial muscle activity; lines present at rest may or may not improve. A treatment may be effective for variable lengths of time with subsequent treatments, may not work as well for as long as expected, or may not work at all. I have been informed of other alternatives which exist for the treatment of wrinkles such as topical Creams, chemical peels, laser treatments, surgical removal of the frown muscles, forehead/brow lift, facelift, collagen or hyaluronic acid treatments. Initial \_\_\_\_\_

**Cost/Fees**

Payment for this cosmetic procedure is my responsibility. Understand that there will be an additional fee for touch ups.

Initial \_\_\_\_\_

**Follow-Up**

I agree to follow-up in 2-4 weeks after my first treatment if asked to do so by my physician.

Initial \_\_\_\_\_

**Photographs**

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and and presentations. I understand my identity will be protected. Initial \_\_\_\_\_

**I have read the above and understand it. My questions have been answered satisfactorily by the doctor and doctor's associates. I accept the risk and complications of the procedure.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date