Botulinum Toxin Consent Form

Informed consent and treatment record for botulinum toxin injections, commonly known as anti-wrinkle injections.

ORGANISATION

DATE

Patient details

FULL NAME

DATE OF BIRTH

DATE OF TREATMENT

MOBILE

EMAIL

GP NAME AND PRACTICE

Medical screening

DO ANY OF THESE APPLY TO YOU

- [ ] Pregnant, planning pregnancy, or breastfeeding
- [ ] Previous allergic reaction to botulinum toxin or albumin
- [ ] Active infection or skin condition at the injection site
- [ ] Autoimmune condition
- [ ] Neuromuscular disorder (myasthenia gravis, ALS, Lambert-Eaton)
- [ ] Bleeding disorder or anticoagulant medication
- [ ] Aminoglycoside antibiotics or muscle relaxants currently
- [ ] Previous facial surgery or implants

ALL CURRENT MEDICATIONS AND SUPPLEMENTS

KNOWN ALLERGIES

RELEVANT MEDICAL HISTORY

PREVIOUS BOTULINUM TOXIN TREATMENTS, PRODUCT AND DATE

ANY PRIOR ADVERSE EFFECT

Risks explained

Each item is initialled by the patient to confirm it was explained and understood.

RISK OR LIMITATION EXPLAINED	PATIENT INITIAL

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Complete the risk rows above with the specific risks discussed, which typically include bruising, swelling, tenderness, headache, asymmetry, eyelid or brow droop, temporary weakness of nearby muscles, treatment failure or reduced effect over time, the need for review at two weeks, and that results are temporary.

Treatment record

Completed by the treating practitioner.

PRODUCT AND BRAND

BATCH NUMBER

EXPIRY

DILUTION

TREATMENT AREA	UNITS	INJECTION POINTS	NOTES

TOTAL UNITS ADMINISTERED

PRESCRIBING PRACTITIONER

INJECTOR, IF DIFFERENT

Aftercare given

- [ ] Remain upright for four hours after treatment
- [ ] Avoid strenuous exercise for 24 hours
- [ ] Full effect takes up to 14 days
- [ ] Written aftercare sheet provided
- [ ] Do not rub or massage the treated area
- [ ] Avoid heat treatments, saunas and sunbeds for 48 hours
- [ ] Review appointment offered at two weeks
- [ ] Emergency contact details provided

Patient consent

- [ ] The nature and purpose of the treatment has been explained to me
- [ ] The risks, side effects and limitations have been explained and I have had the opportunity to ask questions
- [ ] I understand results are temporary and further treatment will be needed to maintain them
- [ ] I understand no guarantee of a specific result has been given
- [ ] I have disclosed my full medical history and current medications accurately
- [ ] I understand I may withdraw consent at any time before treatment commences
- [ ] I consent to clinical photographs being taken for my medical record

PHOTOGRAPHS MAY ALSO BE USED FOR

- [ ] Medical record only
- [ ] Anonymised teaching
- [ ] Marketing, with separate written consent

PATIENT SIGNATURE	PRINT NAME	DATE
PRACTITIONER SIGNATURE	PRINT NAME	DATE