Consent for Restylane and Perlane Injections

Patient Name Date of birth

Legal guardian name (if applicable)

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form will acknowledge your consent to treatment recommended by your physician.

1. I hereby give my consent for Dr. Teresa Girolami to perform Restylane/Perlane injections upon me. I understand that the procedure is to be performed at Bel-Red Internal Medicine, PLLC. This has been recommended to me by my physician in order to improve my facial expression lines with Restylane/Perlane injections.

I understand that the procedure can be described as follows:

Hyaluronic acid is injected with a small needle into the facial muscles. This dermal filler provides fullness and elasticity to your skin. Benefits from the procedure develop within 5-7 days. Maximum benefits should be attained in about 2 weeks and last about 6 months.

1. I understand that Restylane and Perlane are the trademarks for hyaluronic acid. These injections have been used for the treatment of moderate to severe facial wrinkles and folds, such as the lines from the nose to the corners of the mouth (nasolabial folds).
2. I understand that there are potential risks, complications, and side effects associated with any medical procedure. Although it is impossible to list every potential risk, complication, and side effect, I have been informed that some of the possible risks, complications, and side effects of this procedure. These could include, but may not be limited to the following:

Swelling, redness, pain, bruising, and tenderness at the injection site, which typically resolve in less than seven days. Restylane and Perlane are not to be used on women who are pregnant or breastfeeding.

Serious, but rare side effects include delayed onset infections, recurrence of herpetic eruptions, and superficial necrosis at the site of injection. Let your physician know if you have recently been treated with anticoagulant or platelet inhibitors to avoid bleeding and bruising.

This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may make an educated decision. Some of these risks, complications, and side effects are not serious or do not happen frequently. Although these risks, complications, and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure. Although most procedures have good results, I understand that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications, or side effects.

I recognize that during the course of treatment, unforeseeable conditions may require additional or different treatment or procedures than those listed above or discussed with me. I request and authorize my physician and other qualified medical personnel to perform such other treatment or procedures as are, in their judgment, necessary and appropriate.

1. I understand that several sessions may be needed to complete the injection series and that multiple sessions are needed to maintain the results over time.

1. I understand that if I do not keep my follow-up appointment in two weeks, the office will assume my results are satisfactory and any injections after that time will be at full cost.
2. I have been advised of the post-treatment instructions and understand these should be followed to minimize risk of complications. These include instructions to avoid exposure to extreme hot or cold, apply a cold compress to swelling, and to avoid vigorous contact with the treated area for 6 hours after treatment.
3. I certify that I have read or had read to me the contents of this form.

I have read or had read to me and will follow any patient instructions related to this procedure.

I understand the potential risks, complications, and side effects involved with the injection of Restylane/Perlane and have decided to proceed after considering the possibility of both known and unknown risks, complications, and side effects of Restylane/Perlane.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician.

Patient signature Date Time

\*Patient is unable to consent because . I therefore consent for the patient.

Authorized consenter’s signature Date Time

Printed name Relationship to patient

Witness Date Time

By my signature below I attest to the fact that I explained the procedure to the patient.

Printed name

Signature Date Time