

## Section VII

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# VII

# Appendix A: Neurotoxin/Filler Injection Techniques by Advancing Difficulty and Injector's Experience

## Beginner

### BoNTA

- Glabella
- Crow's feet
- Nasal tip lift
- Peau d'orange chin
- Bunny lines

## Fillers

- Nasolabial folds
- Lips
- Marionette lines
- Earlobe rejuvenation
- Mental crease

## Intermediate

### BoNTA

- Forehead
- Oral commissure/DAO
- Lateral browlift
- Chemical browlift
- Liplift
- Smoker's lines
- Necklace lines
- Hypertrophic orbicularis oculi
- Hyperhidrosis axilla
- Décolleté
- Hyperhidrosis forehead and scalp

## Fillers

- Oral commissure
- Pre-jowl sulcus
- Forehead wrinkles
- Chin augmentation
- Temporal fossa
- Acne scars
- Lateral malar prominence
- Submandibular and buccal hollow
- Décolleté
- Mandibular angle
- Cheek lift

## Kybella

## Advanced

### BoNTA

- Nefertiti necklift
- Platysmal banding
- Nasal flare
- Gummy smile
- Masseter hypertrophy
- Hyperhidrosis hands
- Hyperhidrosis feet
- Migraine

## Fillers

- Vertical lip lines
- Refractory glabellar lines
- Medial midface
- Lateral browlift
- Dorsum of hands
- Liquid facelift
- Sculptra

## Expert

### BoNTA

- Frey syndrome
- Submandibular gland hypertrophy
- Parotid gland hypertrophy

## Fillers

- Tear trough
- Rhinoplasty
- Nasal valve stenting
- Medial orbital hollow
- Fine Lines and Skin Boosters
- PMMA

# Appendix B: Sample Informed Consent Form for Neurotoxin Injections

I authorize Dr. \_\_\_\_\_ to perform injection of *Botox/Dysport/Xeomin* on me.

**Indications for procedure:** Facial wrinkles

**Risks of procedure:** Bleeding, bruising, pain, infections, asymmetry, not fully improve wrinkles, temporary drooping of the eyelid, need for additional treatment, may also need filler for improved correction. In addition, there have been reports of distant spread of botulinum toxin that has resulted in secondary problematic weakness. These observations have only been reported in children being treated for spasticity and have never been reported with the cosmetic use of these products.

**Alternative treatments:** No treatment, filler injection, chemical peels, laser resurfacing, etc.

**Photographs:** I give my consent for photographs to be taken before and after the procedure for documentation.

I will allow these photographs to be shown to other patients. My name and other personal information will not be disclosed. YES NO

I will allow these photographs to be placed on the Internet. My name and other personal information will not be disclosed. YES NO

I understand that the results of these injections are not immediate, and it may take 7 to 10 days for the full effect of the injection to be seen.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been given to me concerning the results of this procedure.

Patient\_\_\_\_\_

Date\_\_\_\_\_

Physician\_\_\_\_\_

Witness\_\_\_\_\_

# Appendix C: Sample Informed Consent Form for Filler Injections

I authorize Dr. \_\_\_\_\_ to perform injection of \_\_\_\_\_ on me.

**Indications for procedure:** Facial wrinkles, facial aging

**Risks of procedure:** Bleeding, bruising, pain, infection or inflammation, asymmetry, not fully improve wrinkles, lumps, nodules, vascular injury or occlusion (including tissue loss, necrosis or blindness), scarring, need for additional treatments, delayed hypersensitivity, allergic reaction. *(Additional risk for PMMA: This is a permanent product and cannot be removed.)*

**Alternative treatments:** No treatment, use of a different filler product

**Photographs:** I give my consent for photographs to be taken before and after the procedure for documentation.

I will allow these photographs to be shown to other patients. My name and

other personal information will not be disclosed. YES NO

I will allow these photographs to be placed on the Internet. My name and other personal information will not be disclosed. YES NO

**Anesthesia:** I consent to the administration of anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and allergic reaction.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been given to me concerning the results of this procedure.

Patient\_\_\_\_\_

Date\_\_\_\_\_

Physician\_\_\_\_\_

Witness\_\_\_\_\_

# Appendix D: Sample Informed Consent Form for Kybella Treatment

I authorize Dr. \_\_\_\_\_ to perform injection of Kybella (deoxycholic acid) on me.

**Indications for procedure:** Fat pad under the chin.

**Risks of procedure:** Bleeding, bruising, pain, infection of inflammation, temporary numbness, weakness of the marginal mandibular facial nerve (which can cause a crooked smile), inadequate resolution of the fat.

I understand that multiple treatments are necessary to achieve results, and results are not completely predictable.

**Alternative treatments:** Liposuction, necklift, facelift

**Photographs:** I give my consent for photographs to be taken before and after the procedure for documentation.

I will allow the photographs to be shown to other patients. My name and

other personal information will not be disclosed. YES NO

I will allow these photographs to be placed on the Internet. My name and other personal information will not be disclosed. YES NO

**Anesthesia:** I consent to the administration of anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and allergic reaction.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been given to me concerning the results of this procedure.

Patient\_\_\_\_\_

Date\_\_\_\_\_

Physician\_\_\_\_\_

Witness\_\_\_\_\_