Hyaluronidase For FilLer Dissolving Consent Form

Patient Name	:	sai krishna				Emirates ID	:	784-8666-6666666-7
File No	:	8	DOB	:	1996-09-25	Nationality	:	Other
Gender	:	Male	Doctor's Name	:	test test	Date	:	2024-03-07

Expected Outcome:

An immediate improvement on the treated areas on the same day. Client experiences may vary.

What to do AFTER Hyaluronidase for Fillers Dissolving:

- Avoid drinking alcohol or doing strenuous exercise, as it may result in bruising.
- In case of dissolving lip fillers, avoid smoking & drinking very hot drinks for at least one week.
- Avoid things which increase body temperature like sunbathing, tanning, saunas or hot tubs.
- Avoid itching, massaging, or picking on the injection sites.
- Do cold sponging with an ice pack on the area if swelling or bruising occurs.
- Apply Arnica containing cream or lotion on areas of swelling or bruising.
- For pain take Tab. Acetaminophen (Panadol, Adol) as required.
- Sunscreen and makeup can be applied, and you may use a gentle cleanser on the area.

Side Effects and Complications:

Most side effects are mild or moderate and usually last less than 7 days. The most common side effects include; Temporary injection site reactions such as:

- Swelling
- Pain / tenderness
- Redness
- Bruising
- Discoloration
- Persistence of filler
- Prolonged discoloration of the skin
- Reactivation of cold sores
- Infection, scarring
- Allergic or anaphylactic reaction

I consent voluntarily to undergo this treatment and understand that I have the right to withdraw from the procedure or treatment at any time without in any way affecting my medical care:

- Post-treatment instructions have been explained to me.
- Have had the opportunity to ask questions, which have been answered to my satisfaction.
- I have filled the Filler/Botox/Hyaluronidase Treatment Checklist
- I consent to take clinical photographs of my treated areas for my personal health record only.
- There is NO REFUND for services rendered.

Informed Consent Form Valid Date/s 10/02/2024

'I agree that healthcare provider(s) involved in my care at this facility will access my health information through the Health Information Exchange System (NABIDH) in accordance with the Laws of the United Arab Emirates, Emirate of Dubai Legislation and Dubai Health Authority Policies'

'أوافق على أن مقدمي الرعاية الصحية المشاركين في رعايتي في هذه المنشأة سيتمكنون من الوصول إلى معلوماتي الصحية من خلال نظام تبادل المعلومات الصحية (NABIDH) وفقاً لقوانين دولة الإمارات العربية المتحدة، تشريعات إمارة دبي وسياسات هيئة الصحة بدبي '

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	witness	Doctor
		

Patient Name sai krishna Date 2024-03-07 Parent or Guardian (if patient is minor)Name vv	Witness Name vvv Date 2024-03-07	Doctor's Name test test Date 2024-03-07