

Patient Consent Form

Dysport®

Patient Name: _____ Date: _____

To the patient: Being fully informed about your condition and treatment will help you make the decision whether or not to undergo Dysport® treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I have requested that Westside Aesthetics attempt to improve my fine lines, TMJ (teeth grinding), migraines, excessive sweating, or muscle spasms with Dysport®. These injections have been used for more than a decade to improve the spasm of the muscles around the eye, to correct double vision due to muscle imbalance as well as numerous other neurological uses. Dysport® is now approved by the FDA to improve the appearance of the vertical lines between the brows. A few tiny injections of Dysport® relaxes overactive muscles and soften those vertical lines. Injections in other areas to improve appearance of facial lines have been reported in the literature, but the FDA has not approved those uses. The results of Dysport® are usually dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results.

_____ **Patient Initials**

The Dysport® is injected with a tiny needle into the muscle; you should see the benefits develop over the next two to seven days. A decreased appearance of frowning or creasing of other lines will be the result of this treatment.

_____ **Patient Initials**

The most common side effects are headache, respiratory infection, flu syndrome, temporary eyelid droop and nausea. Dysport® should not be used if there is an infection at the injection site. Additionally, slight temporary bruising may occur at the injection site. I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all.

_____ **Patient Initials**

I understand that the results are temporary and several sessions may be needed for optimal results. _____

Patient Initials

I understand that Westside Aesthetics is asking for a 24 hour cancellation notice for all appointments made from this day forward. _____ **Patient Initials**

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions of the staff at Westside Aesthetics. I consent to this Dysport® treatment today and for all subsequent treatments.

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____