DERMAL FILLER HISTORY, CONSENT & RECORD FORM

Client details

Name:
Address:
Post code:
Email:
Tel/Mobile:
Date of birth:

Please ensure you understand the potential complications and personal requirements of the procedure indicated below, by answering the following questions. If you are unsure of any details, please discuss with the practitioner treating you.

	YES	NO
Are you pregnant, breastfeeding, or is there any possibility that you are pregnant?		
Are you trying to conceive or undergoing any IVF treatment?		
Do you suffer from any known allergies, including topical anaesthesia creams? If yes, please specify.		
Do you suffer from any illnesses e.g. diabetes, angina, epilepsy, hepatitis, HIV positive, any autoimmune disease e.g. crohn's disease, fibromyalgia, me, chronic fatigue, human papillomavirus (HPVO), hashimotos thyroiditis, lupus, lyme disease, multiple sclerosis (MS), myasthenia gravis, arthritis. If yes, please specify		
Are you taking any medication, including the contraceptive pill? If Yes, please specify.		
Have you taken any antibiotics in the last 2 weeks? If yes, please specify.		
Have you taken Roaccutane in the past 6 months?		
Are you attending or receiving treatment from a doctor or specialist at present? If yes, please specify.		
Have you had any surgery or injury in the last 6 months? If yes, please specify.		
Do you have, or have you had, any form of skin cancer? If yes, please specify.		
Do you have a history of anaphylactic shock (severe allergic reactions)?		
Do you suffer from fainting or low blood pressure?		
Do you suffer from keloid or hypertrophic scars? If yes, please specify.		
Have you been diagnosed with any skin conditions? If yes, please specify.		
Do you have a history of cold sores or other skin infections? If yes, when was your last breakout?		
Have you used any laser or skin peels in the last 6 weeks? If yes, please specify.		
Have you been exposed to excessive sun, electrolysis, depilatory creams, or waxing in the last 5-7 days? If yes, please specify.		
Have you previously received any **aesthetic treatments** (eg laser, Botox, dermal fillers, peels, facial fat transfer, plasma etc.)? If yes, please specify which treatment, and when was your last treatment.		
Have you previously experienced any **reactions** from aesthetic treatments (eg Botox, dermal fillers, peels, laser, facial fat transfer etc.)? If yes, please specify.		
Have you ever had treatment of **permanent filler** injections or implants? If yes, please specify.		
Do you have an ocular prosthesis (artificial or glass eye)?		
Are you undergoing any dental work? If yes, please specify		
Have you ever had a tooth abscess? If yes, please specify when		

When was your last visit to the dentist?
When did you last have an alcoholic drink & how many units?
What area/s do you want to treat?
What/where are you hoping to achieve/improve from treatment?

Dermal Filler Treatment Information

The procedure is typically used for skin rejuvenation. This treatment uses a dermal filler medical device to minimise fine lines, wrinkles, and folds, and to create volume to larger areas of the face and hands.

It is moderately uncomfortable; however, a numbing cream may be applied to the skin approximately 30-45 minutes before treatment begins.

Following your dermal filler treatment some **common injection related reactions** may occur:
Redness - Any redness should decrease over 24-hour period. Makeup can be applied to cover any redness once the skin has settled.
Swelling - do not expose the treated area to intense heat or to extreme cold for two weeks following treatment. A clean cool pack can be applied directly to the treated area. Non-prescription anti-inflammatories may prove useful in the reduction of swelling so long as you are medically suitable to take them. However, bruising may be enhanced and/or prolonged with the use of anti-inflammatories.
Bruising – dermal filler injections can cause areas of bruising although this would not normally be expected to occur, the eye contour being the area at most risk. Any such bruising will be temporary. If you are taking any medication or dietary supplements that can affect platelet function and bleeding time, the severity and period of bruising can be extended. Be aware that taking aspirin or similar medication may increase the likelihood of bruising. Arnica cream and/or tablets can help to minimise and resolve bruising more quickly. Make-up can be applied to cover bruising approximately 4 hours post treatment.
Tenderness or discomfort at injection site for 24-72 hours following treatment - non-prescription analgesia can be taken.
Itching may occur for 7-14 days following treatment - Non-prescription anti-histamines may alleviate any itching.

These sensations will usually typically resolve within days and many people are able to return to their normal activities the same day. Some people may react differently and may experience these reactions for longer. However, these reactions are temporary and typically resolve within 7-14 days as the skin returns to normal.

Less common side effects include:

- Raised bumps in or under the skin (nodules or granulomas) that may need to be surgically removed
- Infection
- Open or draining wounds
- A sore at the injection site
- Allergic reaction
- Necrosis (tissue death)

Rare side effects have also been reported:

- Severe allergic reaction (anaphylactic shock) that requires immediate emergency medical assistance
- Migration/ movement of filler material from the site of injection
- Leakage or rupture of the filler material at the injection site or through the skin (which may result from tissue reaction or infection)
- The formation of permanent hard nodules in the face or hand
- Vision abnormalities, including blindness
- Stroke
- Injury to the blood supply
- Damage to the skin or the lips

Post Treatment Advice

It is advisable to:

- Refrain from touching the treated areas with your hands until the pores have had chance to close. This is to reduce the risk of infection at the site of injection.

- It is recommended that the use of soaps, other than those recommended by your practitioner, on the treated skin area is restricted until the redness subsides and where possible warm / tepid water and / or gentle skin cleansers are used for cleansing. Do not scrub. Pat to dry only.
- Refrain from intensive sun light (e.g. sunbeds and sunbathing), saunas, steam bath or extreme cold for a period of at least 2 weeks.
- Avoid electrolysis, waxing, bleaching of treated area for 72 hours.
- Avoid alcohol 48 hours after treatment.

Consent

I understand this treatment is an elective medical-cosmetic treatment and hereby acknowledge the following:

	Yes	No
I confirm that to the best of my knowledge the health history that I have supplied is correct and that there is no other medical information I need to disclose.		
I further understand that withholding any medical information may be detrimental to my health and safety during the treatment in which I agree to undertake.		
I understand that if there is any change in my medical history, it is my responsibility to advise the practitioner before further treatments are carried out.		
I have been informed in detail and understand possible risks, conditions, reactions, side effects associated with the treatment and I understand that the development of any reactions/side effect must be reported to the practitioner as soon as possible.		
I understand that a medication named hyaluronidase may be required to dissolve the filler in the event of an emergency.		
I understand I may require a series of treatments, normally with at least 6 weeks between procedures, to achieve the maximum cosmetic result.		
I certify that I will make available where possible any follow-up visits as my practitioner advises if required - approximately 2-6 weeks.		
The effects of treatment will vary with some patients than with others and I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no written, implied, or verbal guarantee that the anticipated results will be achieved.		
I have understood and agree to follow above post treatment advice given in the form of **a leaflet** in the knowledge that deviation can cause a disappointing result and, in some instances, can pre-dispose me to side effects and reactions to treatments.		
The treatment has been explained to me by the practitioner and I have had the opportunity to ask questions and that these have been answered to my satisfaction and I confirm that I have been allowed sufficient time to make a carefully considered decision.		
I understand that pre and post-treatment photographs will be taken and that these will be used for assessment reasons. I can confirm these images are taken with my knowledge and I consent to them being placed in my file.		
I consent to photographs being used for educational, training, teaching, and lectures.		

I consent to photographs being used for:		
Website		
Facebook		
Instagram		
Twitter		

	Yes	No
I have read the above consent and I confirm that by signing this form I consent to undergo treatment. I understand that I am free to withdraw my consent at any time.		

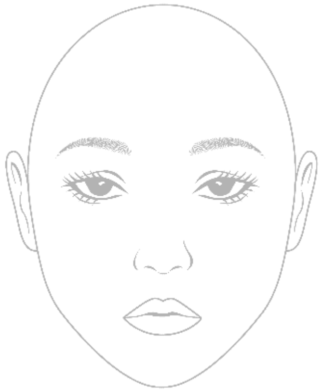
Date:	Time:	Client Print Name	Client Signature
Date:	Time:	Client Print Name	Client Signature
Date:	Time:	Client Print Name	Client Signature

OFFICE USE ONLY   Client Name:

Date:	Time:	Photograph taken: YES / NO	Cleanser:	Anaesthesia:	Sterile Pack Lot No: Expiry Date:

Filler Type:
Filler Lot No:
Filler Expiry:
Volume Injected:
Area Injected:
Cannula Size:
Cannula Lot No:
Cannula Expiry:

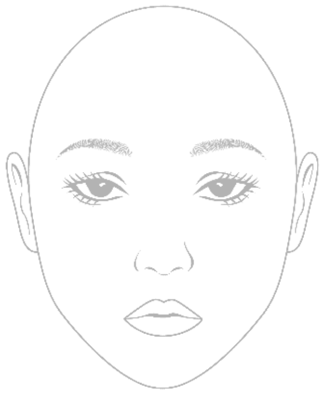
Administered by:



Date:	Time:	Photograph taken: YES / NO	Cleanser:	Anaesthesia:	Sterile Pack Lot No: Expiry Date:

Filler Type:
Filler Lot No:
Filler Expiry:
Volume Injected:
Area Injected:
Cannula Size:
Cannula Lot No:
Cannula Expiry:

Administered by:



Date:	Time:	Photograph taken: YES / NO	Cleanser:	Anaesthesia:	Sterile Pack Lot No: Expiry Date:

Filler Type:
Filler Lot No:
Filler Expiry:
Volume Injected:
Area Injected:
Cannula Size:
Cannula Lot No:
Cannula Expiry:

Administered by: