
BOTULINUM TOXIN TYPE A
(BOTOX COSMETIC)

Botox is made from Botulinum Toxin Type A, a protein produced by the bacterium *Clostridium botulinum*. For the purpose of improving the appearance of wrinkles, small doses of the toxin are injected into the affected muscles blocking the release of a chemical that would otherwise signal the muscle to contract. The toxin thus paralyzes or weakens the injected muscle. The treatment usually begins to work within 24 to 48 hours and can last up to four months. The Food and Drug Administration (FDA) approved the cosmetic use of Botulinum Toxin Type A for the temporary relief of moderate to severe frown lines between the brow and recommends that the procedure be performed no more frequently than once every 3 months.

It is not known whether Botulinum A Toxin can cause fetal harm when administered to pregnant women or can affect reproductive capabilities. It is also not known if Botulinum A Toxin is excreted in human milk. For these reasons, Botulinum A Toxin should not be used on pregnant or lactating women.

I authorize and direct **Nassif E. Soueid, M.D.**, with associates or assistant of his choice, to perform the following procedure of Botulinum A Toxin injections(s) on _____ for the treatment of _____.

e.g., brow, forehead, crow's feet, etc.

- _____ The details of the procedure have been explained to me in terms I understand
- _____ Alternative methods and their benefits and disadvantages have been explained to me.
- _____ I understand that the FDA has only approved the cosmetic use of Botulinum A Toxin for frown lines between the brow. Any other cosmetic use is considered off-label
- _____ I understand and accept the most likely risks and complications of Botulinum A Toxin injection(s) include but are not limited to:
- Paralysis of a nearby muscle that could interfere with opening the eye(s)
 - Local numbness
 - Headache, nausea or flu-like symptoms
 - Swallowing, speech or respiratory disorders
 - Swelling, bruising or redness at injection site
 - Disorientation, double vision or past pointing
 - Temporary asymmetrical appearance
 - Abnormal or lack of facial expression
 - Inability to smile when injected in the lower face
 - Facial pain
 - Product ineffectiveness
- _____ I understand and accept that the long-term effects of repeated use of Botox Cosmetic are as yet unknown.
- Possible risks and complications that have been identified include but are not limited to:
- muscle atrophy
 - nerve irritability
 - production of antibodies with unknown effect to general health
- _____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with this procedure
- _____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.
- _____ I have informed the doctor of all of my known allergies
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and any others.
- _____ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.
- _____ I am aware and accept that no guarantees about the results of the procedures have been made or implied.
- _____ I have been informed of what to expect post-treatment, including but not limited to: estimated recovery time, anticipated activity level, and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.
- _____ I am not currently pregnant or nursing, and I understand that should I become pregnant while using this drug there are potential risks, including fetal malformation.
- _____ If pre-and postoperative photos and/or videos are taken of the treatment for record purposes, I understand that these photos will be the property of the attending physician.
- _____ I understand that these photos may only be used for scientific or record keeping purposes.
- _____ The doctor has answered all of my questions regarding this procedure.
- _____ I have been advised to seek immediate medical attention if swallowing, speech or respiratory disorders arise.

Patient Consent

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

Patient Signature

Witness Signature

Print Patient Name

Print Witness Name

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Physician Certification

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

Physician Signature

Date

Copy given to patient
_____ Date

Initials

Original filed in chart
_____ Date

Initials