

Patient Information and Consent

Contact Information

Medical History

Required Information

Title _____
First name _____
Surname _____
Address _____

Tel home _____
Tel work _____
Mobile _____
Email _____
Date of birth _____
Occupation _____

List previous surgical and non-surgical facial cosmetic procedures

date _____ date _____
_____ date _____
_____ date _____

Have you been injected with Poly-L-Lactic Acid (Sculptra) or Polyacrylamide (Aquamid) within the last 3 years?

Yes No

Optional information

GP _____
Name _____
Address _____

List surgical and non-surgical cosmetic procedures you are interested in _____

Notes _____

It is important to answer the following questions as accurately as possible. If you are not sure of the answer to any of the following questions, you should ask your physician before proceeding with a Radiesse treatment.

Have you suffered from	YES	NO
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies or anaphylactic (severe) reactions	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Facial Herpes Simplex.....	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia nervosa / Bulimia nervosa.....	<input type="checkbox"/>	<input type="checkbox"/>
Any surgical operations.....	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders / depression	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____		
Drug dependency / alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____		

Other Conditions	YES	NO
Are you pregnant or breast feeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Taking steroids, aspirin or anticoagulants..... (medication to minimise blood clotting)	<input type="checkbox"/>	<input type="checkbox"/>
Taking any other kind of medication	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____		
Have you had any kind of facial implant.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____		
Have any other kind of medical condition	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____		

Signature _____
Date _____

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Client Acknowledgement & Consent

By signing the bottom of this page I hereby acknowledge the following:

1. That I have discussed the nature of my condition, the contemplated procedure, the general nature of the proposed treatment, and the circumstances and basis upon which I have made a request for the proposed treatment.
2. That the prospects for success and likely benefits of such treatment have been fully discussed with me to my satisfaction.
3. That the possible risks of this treatment have been thoroughly discussed with me to my satisfaction, and that I have been told that the possible risks of this treatment include but are not limited to poor cosmetic result, extrusion, infection, folds or lines, the need for possible further treatment, nodule formation, swelling, allergic reaction and inadequate augmentation.
4. That I have been advised that there may be other particular risks associated with the procedure because of my medical condition(s), including: _____

_____ (insert risks here, if any)
5. That the nature of the procedure itself has been explained to me as well as alternative methods available and any disadvantages and advantages of one method over another.
6. That although good results are expected, the possibility and nature of complications cannot be definitively stated and that, therefore, there can be no guarantee either as to the success or otherwise of the treatment.
7. That the augmentation is not permanent as degradation of the implant material will occur over time.
8. That I have been given an opportunity to ask any questions that I have and that my questions have been answered in a full and satisfactory manner.
9. That I have had the opportunity to seek medical advice from my general practitioner if I want to before deciding to proceed with this procedure.
10. That before signing this document any blanks on this page where details are to be inserted regarding risks and any named physician and/or associate or assistant have been completed.
11. That before signing this document I have read it (or it has been read to me) and that I understand the information contained in this document and the nature of the acknowledgements and

consent I am giving.

12. That the information collected in this form is necessary information to ensure I receive the most appropriate procedure and that all risks are avoided as far as possible.

Consent

I hereby authorise and consent to the named physician and/or associate or assistant of his/her choice performing the injection of the tissue augmentation product Radiesse and any other procedures that in his/her judgment are advisable for my wellbeing as required during or arising out of the injection procedure.

Name/Names of Physician(s) _____

My Name _____

My Signature _____

Date _____

Place _____

Please turn over for Contact Information and Medical History Form